University of Alberta

PARENT EXPERIENCES OF THE ALLIANCE WITH THEIR CHILD'S THERAPIST

by

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DEDICATION

Taking on a research project of this size was a challenge especially from the other side of the country. While technology allowed me to do this project from a distance at times it also slowed us down and led to frustration. I want to thank my supervisor Robin Everall for her support throughout this process especially in dealing with uncooperative files and repeated computer crashes. I want to express thanks also to my committee for their feedback and suggestions and especially Barbara Paulson for her support over the last eight years of my education.

I want to dedicate this project to my parents who themselves know what it is like to have a child in treatment. I watched you struggle with these issues throughout the years and you have inspired me to try to understand and improve what parents experience when their child is in therapy. I hope this project can bring you some sense of comfort.

To my sister, Tammy, I wish you could have made it to see what I have accomplished. I often wonder if it would have made a difference, I know you would be proud. I can only wish that you have found some peace.

Throughout this project my family has sacrificed the most. To Kaylee, Mackenzie and Miranda, you each have given up precious time with your parents. Our time will now be ours. Your zest for life and unconditional acceptance and understanding are an inspiration. Finally, to my husband John, you have provided quiet, unwavering support. And yes, I know we have a car, I do not need to ask.

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CHAPTER ONE

Introduction

Children rarely bring themselves to therapy (Kazdin, 2000; Shirk & Karver, 2003) as it is not the child who initiates treatment or makes the referral. Parents play a variety of roles in their child's therapy besides initiating or discontinuing treatment. Parents can provide the therapist with information regarding the emotional state and behaviour of their child. Parents likely are the most important source of information about all aspects of the child (Sperling, 1997). Parental influence outside the therapeutic environment is important to facilitating the change process and maintaining coping and therapeutic improvements (Kazdin & Weisz, 1998; Knox, Albano, & Barlow, 1996; Mendolowitz, Manassis, Bradley, Scapillato, Miezitis, & Shaw, 1999; Multisystemic Therapy Services, 1998; Spence, Donovan, & Brechman-Toussaint 2000). As with other situations a child is exposed to (e.g., education, social, home) it is usually the choice of the parent to terminate the therapeutic process at any time.

When a parent decides to seek services for a child there are many places that child therapy can take place: mental health clinics and hospitals, family therapy centres, or private practitioners. Parents engage their children in therapy with their own expectations (Bonner & Everett, 1986; Nock, Phil, & Kazdin, 2001; Nye, Zucker, & Fitzgerald, 1999) and for many parents this is a new experience with which they have little previous experience. The role of the therapist is essentially the same: to assess the child and family and assist in the development of goals for therapy with the overarching goal being symptom reduction and improvement in quality of life. The shape for the therapy tends to be determined largely by parent report of the problem (Yeh & Weisz, 2001) with the role parents play in the child's therapy often left to be decided by individual therapists who have varying approaches. Despite the fact that parents and therapists are both integral to the child's therapy, there has been little attention paid to the parent-therapist relationship in the literature (DeVet, Kim, Charlot-Swilley, & Ireys, 2003). The importance of parental involvement in the treatment process needs to be stressed (Bernstein, 1996) and an understanding of the parent's experience is vital for providing intervention for children as it allows practitioners to prepare families for the experience (Webster-Stratton & Spitzer, 1996).

Different theoretical orientations highlight different factors considered important in conducting successful therapy. For example, the theoretical underpinnings of family therapy purport that change in family structure and functioning would bring change in the child's symptoms that continues after therapy ends (Cottrell & Boston, 2002; Nichols & Schwartz, 1998). Here changes in the individual impact the family system in total (Loukas, Twitchell, Piejak, Fitzgerald, & Zucker, 1998). Individualistic theories like cognitive-behavioural challenge the thought process of the child in an attempt to change how one thinks, feels, and behaves (Kendall, 2000). Regardless of the theoretical orientation of the therapist the parent plays an important role in the facilitation of the child's therapy (Rey, Plapp & Simpson, 1999) meaning that child and parent are the client adding to the complexity of the therapist's task (Hawley & Weisz, 2003). A goal of child therapy is to meet the needs of the family (Rey et al.) which includes both parent and child.

My interest in this topic has come from both professional and personal experiences. Due to my own family experiences and experiences obtained through practicing psychology, I have witnessed parents who experience difficulties and struggles when their child is in treatment. Over several years I witnessed not only my own experience as a sibling, but the struggles that my parents encountered trying to help their child with a mental health disorder. These experiences have developed into an interest in working with children and their families, an appreciation of the importance of parents in therapy with children, and consequently this research.

These experiences have led me to question how parents experience the relationship with their child's therapist. This is an important question to contribute to the development of children's treatment services, for the training of therapists, and most importantly to enhance professional practice and provide quality service to families. The questions concerning parents' experience of the relationship with their child's therapist that were investigated in this study are as outlined:

1. What was the parents' experience of the relationship with their child's therapist?
2. What expectations, if any, did parents have of a relationship with the therapist and what role did they expect to play in their child's therapy?

Scope and Purpose

The following study attempts to provide an understanding of the experience of parents with their child's therapist through the theoretical framework of ecological systems theory. Interviews following the end of treatment were conducted with parents who had taken their child for therapy at a university-based counselling centre and explored their perceived experiences as they progressed through the therapy process. Parents' experiences while their child was in therapy were explored. Participants were given the opportunity to discuss the importance of the relationship developed with the child's therapist, the expectations they had for the relationship with the therapist, and what role they expected to play in their child's therapy. A semi-structured interview format was used to allow freedom for participants to discuss important issues of their experience that they determined to be most relevant and influencing. The methodology used was as described by Merriam (2002) as a basic interpretive qualitative study where the purpose is to attempt to understand the experience of parents from their own world view. Colaizzi's (1978) approach to thematic analysis was used to analyze the data collected.

Significance of the Study

The question of this study was to understand how parents experience the relationship with their child's therapist when a child has undergone therapy. Currently there are no published studies investigating the parents' relationship or alliance with the child's therapist (Devet et al., 2003). A review of psychotherapy outcome research concluded that counselling "is a process that most clients who remain involved in for at least a few sessions will benefit from" (Whiston & Sexton, 1993, p. 43). While it is acknowledged that counselling is a beneficial process, most of what is known about counselling is from the point of view of the therapist or the researcher (Patton & Jackson, 1991; Rennie, 1995; Stith, Rosen, McCollum, Coleman, & Herman, 1996).

The majority of research has focused on adult psychotherapy (Digiuseppe, Linscott, & Jilton, 1996; Kazdin, 1994) until recently. While there have been considerable advancements in child psychotherapy research in the last few years the conclusions that can be drawn have been hampered by the focus on child symptom reduction (Kazdin, 2000). Research in the area of child psychotherapy lacks relevancy to how the child experiences therapy (Digiuseppe et al., Stith et al.). There is also a failure to include parents in the evaluation of therapy outcomes (Digiuseppe et al.) and researchers have only recently begun to move away from the therapist's perspective through asking family members for their perceptions (Stith et al.). Little is known about the role of relationship processes in child therapy (Shirk & Saiz, 1992; Shirk & Karver, 2003). As the child predominately functions within a family context the experience of parents concerning their relationship with the child's therapist is an important viewpoint since the child's behaviour has consequences which affect parents (Webster-Stratton & Spitzer, 1996) and vice versa. Understanding parents' experiences will broaden current understanding of child psychotherapy beyond the perspective of the child's symptom reduction and will help to acknowledge the role parents play in the child's therapy and potentially in the child's therapy outcome.

Order of Presentation

In Chapter Two, Review of the Literature, current literature through which child psychotherapy has been investigated is discussed highlighting family experiences. This leads to a discussion of the role of the parent in therapy and the importance of the therapeutic alliance in therapy.

In Chapter Three, Methods, issues related to the qualitative research approach to this project and how the method applies to understanding parent experiences in psychotherapy are discussed. The guidelines used to select and interview participants in the study are outlined followed by a description of the data analysis and ethical considerations.

In Chapter Four, Introductions to Participants, a synopsis of each participant is provided through a description of their experience beginning with considering treatment to treatment ending. Seven parents were included in this study, six mothers and one father. These individuals account for six individual children, as one set of parents attended together for one child.

In Chapter Five, Results, the data gathered through the interviews with the participants is presented highlighting the themes that emerged from the analysis and evaluation of the interviews. Excerpts of the interviews are introduced to support and substantiate the themes. Both the commonalities and idiosyncrasies are highlighted within the participants' experiences to allow for understanding of the shared experience while preserving the individual flavour of each.

In Chapter Six, Discussion, the identified themes are discussed in relation to the reviewed literature. Conclusions are also discussed within the context of this literature. Implications for future research, limitations of the study, and recommendations for practitioners concerning the role of parents in child psychotherapy are discussed.

CHAPTER TWO

Review of the Literature

A recent review of the literature by DeVet et al. (2003) concluded that few studies have examined the child psychotherapy process and that none had investigated the parent relationship with the child's therapist. The following review of literature is intended to provide a context for inquiry into the parent-therapist relationship. The discussion entails a review of family systems literature, family perspectives of mental health services, adult and child psychotherapy literature related to the therapeutic alliance, and expectations for therapy.

The Family as a System

As described by Bor, Legg, and Scher (1996), systems theory is the understanding of ideas within a wide social context. Within a system there is a series of interconnected elements, characterized by circular feedback loops. General Systems Theory model was founded by Ludwig von Bertalanffy (1964) who wondered whether the laws that applied to other biological organisms may also apply to more complex social systems. General Systems Theory supposes that living things are seen as a group of elements interacting with one another and containing boundaries both within themselves and between themselves and the environment (Cottrell & Boston, 2002; Bertalanffy). Properties such as wholeness and non-summativity (whole greater than sum) and feedback loops, which maintain homeostasis or functioning of the system, have been taken from general systems theory and applied to family functioning and therapy (Cottrell & Boston). From a system emerges the relationship of its parts highlighting that a family is more than just a collection of people (Bertalanffy, 1964).

Families minimally satisfy the defined criteria for a system (Bor et al., 1996). Within a family system, the family operates in a circular fashion in which the behaviour of one member affects the other members of the family (Nichols & Schwartz, 1998). The family is both biologically and socially constructed; however, the experience of family members cannot be determined biologically (Bor et al.) but can be conceptualized as a unit or system of interacting personalities (Loukas et al., 1998). Consequently, the behaviour of any member of the family system affects all other members whose response in turn affects the system again (Nichols & Schwartz). This is a multi-directional relationship. Often when people are seen in individual therapy a unidirectional perspective holds forgetting the impact that others have on individuals and the impact that therapy has on others. The relationships within the family system are characteristic of the multiple feedback loops of systems and families in which if one part of the system experiences distress, it is experienced throughout (Everett & Volgy, 1993).

The multi-directional impact is seen in the level of distress that parents who bring their child to therapy experience as a result of the child's difficulties as well as in the impact that a parent with psychopathology can have on a child. A child is more likely to experience mental health issues when a parent also has psychopathology. The impact of parental psychopathology on the child is related to both internalizing and externalizing disorders (Berg-Nielsen, Vikan & Dahl, 2002; Brennan, Hammen, Katz, & Le Brocque, 2002). Likewise, parents of children with Tourette's disorder are at higher risk for psychological distress compared to parents of children with physical illness (Cooper & Livingston, 2003).

Family Therapy

Family therapy has applied a systemic view of families to therapy with families. There are several conceptualizations of family functioning within this orientation. Family therapy, in its traditional form, draws on systemic, cybernetic, narrative, or constructionist theories, with more recent influences from cognitive-behavioural theories (Cottrell & Boston, 2002). For example, structural family therapy (Cottrell & Boston; Nichols & Schwartz, 1998) views the family as a structure of behaviour patterns intended to fulfill the needs of the family. The family is viewed as comprised of subsystems such as parents together, or parent interacting with child. The goal is to cause change to occur by restructuring family interactions within subsystems, such as strengthening parental authority to reduce the problem behaviours. Change within one subsystem is expected to result in change throughout the family system (Cottrell & Boston; Nichols & Schwartz). The therapist's role is to actively move in and out of relationships with family members and to direct family members to change patterns in therapy (Cottrell & Boston). Structural therapy focused on the boundaries (or lack of) within the subsystems of a family. Strategic therapy (Cottrell & Boston; Nichols & Schwartz), on the other hand, has focused on the concept of equilibrium and that the family needs the problem to maintain functioning or homeostasis. Families are given direction to stay the same with the intention of having a paradoxical effect (Cottrell & Boston).

More recent development has shown the emergence of family-based therapy (Diamond, Diamond, & Liddle, 2000). Critics of traditional family therapy allege that the conceptualization of the family as the cause of the child's problem can make building an empathic relationship difficult (Modrcin & Robison, 1991). Early family therapy models ignored individuals functioning for the sake of the family with more recent family-based approaches seeking a balance between the individual and family needs in understanding and treating the problem (Diamond, Diamond, & Liddle). Family-based treatments are characterized by members of a family meeting with a therapist who may use any number of techniques such as strategic, structural, cognitive-behavioural, or psychodynamic (Clarkin, Carpenter, & Fertuck, 2003). Reviews of family therapy literature conclude that family therapy is effective when compared to no therapy but a lesser although significant effect remains when compared to other treatments (Clarkin et al.; Cottrell & Boston, 2002).

Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner (1977, 1979, 1986, 1992) proposed a theory of development that incorporated the interactions of the individual within the larger contexts of systems and emphasized the effects of interactions between the contexts. His ecological systems theory was developed as an extension of Kurt Lewins' classic theory (Bronfenbrenner, 1977) which conceptualized behaviour as a function of both person and environment. Bronfenbrenner expanded Lewins' theory of behaviour by positing that development is a function of both the person and their interacting environment.

While the application of systems theory to families as discussed above takes into account the interactions among family members, it fails to recognize, as Bronfenbrenner (1977, 1979, 1986, 1992) does, that the family is a social system that exists within the larger ecological system of interactions. His ecological system theory expands beyond the family setting to the "examination of multiperson systems of interaction...[taking] into account aspects of the environment beyond the immediate situation containing the subject" (Bronfenbrenner, 1977, p. 514). Therefore, the family is viewed as a system that exists within larger social systems, all of which have reciprocal interacting effects with the environment that cannot be reduced to one-to-one relationships. This perspective extends the system boundaries from around the family by emphasizing that interactional effects are multi-directional rather than unidirectional. Individuals are seen as embedded within families, families within neighbourhoods, neighbourhoods within communities, and communities within society. Bronfenbrenner described four levels of interacting systems that include the microsystem, the mesosystem, the ecosystem, and the macrosystem.

The microsystem involves "a pattern of activities, roles and interpersonal relations experienced by a developing person in a given face-to-face setting with particular physical and material features, and containing other persons with distinctive characteristics of temperament, personality and systems of beliefs" (Bronfenbrenner, 1992, p. 227). According to this definition the family is a microsystem characterized by a continuous pattern of interaction within its members.

A mesosystem "comprises the linkages and processes taking place between two or more settings containing the developing person (e.g., home and school, school and workplace, etc.). In other words, a mesosystem is a system of microsystems" (Bronfenbrenner, 1992, p. 227). The ecosystem is an environment in which an individual is not directly involved but affects him or her anyway. An example of an ecosystem is the child's parents' workplace. Finally, the macrosystem is the larger cultural context.

The interacting relationship of the child and the therapist is an existing microsystem, as is the interactions of the parent with the therapist. The conjunction with the family microsystem is viewed as a mesosystem. Therefore, the connections between the child's therapy and the family is viewed as a mesosystem. Since the processes operating in the various contexts of a mesosystem are not independent of each other in that the home interactions can affect school, and vice versa (Bronfenbrenner, 1986), it stands to reason that the relationship patterns of the child and therapist, and of the parents with the child's therapist, have effects on the family microsystem that have reciprocating effects on the therapeutic process.

Bronfenbrenner (1986) suggests that the linkages and connections between the family and a setting are important and deserve further evaluation. He states that attention is seldom paid to relations between settings or outside the microsystem and that investigations of mesosystems focus only on the direct effects on the child. The failure to examine more than the effects of the interactions of a mesosystem on the child are evident in Bronfenbrenner's following hypothesis:

> The developmental potential of settings in a mesosystem is enhanced if the role demands in the different settings are compatible and if the roles, activities, and dyads in which the developing person engages encourage the development of mutual trust, a positive orientation, goal consensus between settings, and an evolving balance between power in favour of the developing person...of key importance in this regard is the inclusion of the family in the communication network (for example, the child's development in both family and school is facilitated by the existence of open channels of communication in both directions). (Bronfenbrenner, 1979, pp. 212, 216–217)

Based upon Bronfenbrenner's perspective, the interactions within the mesosystem of the parents and their child's therapy is worthy of study. It stands to reason that the quality of connections and interactions between the parents and their child's therapist has an impact on parents' experience of their relationship with their child's therapist, the expectations parents have, and the role they play in their child's therapy process. This places the context of the child therapy process within the larger context which incorporates a multi-directional interaction with the child, parents, and therapist.

Research on Family Systems and Therapy

A review of the literature indicated that limited research attention has been given to the child's and parents' experiences over the course of therapy (Weisz, Huey, & Weersing, 1998). In the family system, the parents as members within the microsystem are affected by the behaviours and experiences of their child, and vice versa. When change occurs, it affects not only individual members but relationships and the system itself (Loukas et al., 1998). Thus, parents are affected when their child enters therapy and this in turn affects the child and the therapeutic process. The focus is on the patterns of interactions between individuals (Street, 1996) embedded within a larger social context. Each family member has a different perspective on the experience (Bor et al., 1996) and hence, a parent experiences their child in therapy differently from how the child experiences this phenomenon.

The fact that children are active participants within the complexities of an ecological system and do not live an isolated existence in a sterile environment (Weisz et al., 1998) is acknowledged within systems theory. In spite of this knowldege there continues to be a lack of research into the experiences of parents and the impact of the child's therapy on the family or family interactions. In a phenomenological study of parental experiences during their child's health crisis, Mu and Tomlinson (1997) concluded that studies of parental experiences of hospital-related stress primarily focused on the mother. Similarly few researchers of child psychotherapy have conceptualized the family as a whole unit or system with those who do primarily investigating dyadic interactions (Loukas et al., 1998).

A qualitative study by Webster-Stratton and Spitzer (1996) focused specifically on the experience of parents during treatment of their child diagnosed with conduct disorder. Not surprisingly, the researchers discovered that the family system experienced a high level of stress. They further concluded that having a child with conduct problems "introduces significant stresses into her or his family system, and, moreover, that these stresses have a cumulative effect on the parents" (Webster-Stratton & Spitzer, p. 21–22).

Further, the researchers' review of the literature indicated that little is known about the parents' point of view as they try to cope with this stress. Themes that emerged following exposure to parent training videos while their child received counselling included more effective coping strategies, increased acceptance of their child and themselves, and an ability to access supports.

A challenge for family therapies to measure outcome is the direct involvement of multiple individuals in the therapy process. Few child psychotherapy studies measure symptom change or outcome outside of the child (Cottrell & Boston, 2002; Kazdin, 2002). Cottrell and Boston discuss the challenges of family therapies concerning which domains to evaluate given the emphasis on the child and family in problem conceptualization and therapy and the difficulty to manualize family therapy. These challenges may explain the lack of family therapy outcome literature (Clarkin et al., 2003; Cottrell & Boston, 2002) and the tendency for studies to focus on family-based cognitive-behavioural approaches rather than traditional family therapy models (Clarkin et al.).

To summarize the literature reviewed, the family is a microsystem that exists within larger systems, all of which have reciprocal interacting effects with the environment that cannot be reduced to one-to-one relationships. As members of the family microsystem and the larger mesosystem incorporating their child's therapy, it is assumed that parents are affected by their child undergoing therapy and that the child's therapeutic process is impacted by the parents' perceptions and involvement. Children experiencing emotional or psychological difficulties introduce stress into the family

(Modrcin & Robison, 1991; Webster-Stratton & Spitzer, 1996) and little is known about how parents experience this stress or the treatment of the child. The experiences of parents are given little attention in the research and thus are an area requiring investigation.

Family Perspectives of Mental Health Services

Families of Adult Clients

Research on the experiences of families involved in the mental health system has primarily focused on families who are coping with adult children receiving treatment. The majority of individuals studied are the mothers of adult men who were diagnosed as suffering from schizophrenia with few studies including fathers, siblings, spouses, or children of sufferers (Winefield, 2000). While the majority of the research is conducted on families with adult children the findings are relevant here to highlight the lack of inclusion that many families experience when a family member is receiving treatment. What is not indicated by the literature is whether these experiences have changed significantly since the child has become an adult or whether the experiences were consistent since the commencement of treatment which may have begun in childhood or adolescence.

The families of adult children receiving treatment identified that health care professionals do not listen to, understand, or realize the weight of the family burden (Conn & Francell, 1987; Dixon, 1997; Francell, Conn, & Gray, 1988; Vaddadi, 1996; Veltman, Cameron, & Stewart, 2002; Winefield, 2000), are unhelpful (Francell et al.; Grunebaum & Friedman, 1988), provide unsatisfactory services (Cook, Pickett, &

Cohler, 1997; Lefley, 1996; Vaddadi; Winefield, 2000), and do not consider the family as important (Furlong & Leggatt, 1996). As well it was felt that many professionals erect barriers through their reluctance to give families basic information about diagnosis, treatment plan, or future course of illness (Backer & Richardson, 1989; Conn & Francell; Lefley, 1989, 1996, 1997; Sveinbjarnardottir & de Casterle, 1997; Winefield).

Further, families reported that members of the mental health community perpetuate the stigma through the suggestion that mental illness is the result of dysfunctional families and "parental toxicity" (Dubin & Fink, 1992; Grunebaum & Friedman, 1988; Lefley, 1992). Until recently families were considered to be causal agents for mental health problems (e.g., schizophrenogenic mother) (Lefley, 1989; Sommer, 1990). However, through the discovery of biological basis of mental disorders, the emphasis is now shifting toward the medicalization of mental disorders (Sommer, 1990). Even though focus has shifted away from parental toxicity, families continue to report having experienced stigmatization and distress (Backer & Richardson, 1989; Lefley, 1996; Vaddadi, 1996; Veltman et al., 2002; Wahl & Harman, 1989; Winefield, 2000). Siblings often are reluctant to become involved, partly due to a desire to keep the mental illness of their relative secret which sustains the feelings of isolation and alienation from society (Winefield). Research demonstrates, however, that blaming parents induces guilt (Bernheim, 1989; Lefley, 1996), alienates the family from the health professionals as their feelings of fear and shame escalate, and thus places them in a defensive position (Conn & Francell, 1987).

Research evaluating the impact of therapy on significant others demonstrates that in couples, one partner's therapy affects the partner who is not in therapy (Brody & Farber, 1989). While the impacts on significant others reported tended to be mostly positive, it is noteworthy that those significant others who seemed most ambivalent and unsure were those who seemed to know the least about their partner's therapy. The unknown process of therapy can result in doubts and insecurities (Brody & Farber).

Families of Child Clients

Similar findings to adult studies are reported in an evaluation of parents' perspectives of children's mental health services (Tarico, Low, Trupin, & Forsyth-Stephens, 1989). These findings were confirmed by a study of parent perspectives of children with psychological or emotional problems. The researchers (Tarico et al.) found that parents wanted more information regarding treatment and felt alienated by the blame and criticism which was directed towards them by those providing services. This experience of feeling blamed was an inhibitor to the treatment for the child. Lack of family-professional agreement and lack of family involvement are the major contributors to dissatisfaction (DeChillo, Koren, & Schultze, 1994).

Cooper and Livingston (2003) compared experiences of parents with children with Tourette's disorder and children with asthma and found that the mothers of children with Tourette's disorder have significantly greater burden in all areas measured. The authors (Cooper & Livingston) report that parents of children with Tourette's disorder were more likely to be psychologically ill than parents of children with asthma. Parents of children with Tourette's disorder experienced greater burden in maintaining relationships, well-being, and activities. Although there were demographic differences between the two populations, the only predictor of parental psychological illness was the diagnosis of Tourette's disorder in the child suggesting the impact is over and above the general effect of having a child with a physical illness. Mothers, however, experienced greater psychological illness and appeared to carry a greater proportion of the caregiver duties in this population than fathers (Cooper & Livingston).

Families experience a constant struggle with the mental health system (Veltman et al., 2002). Due to the difficulties experienced by families in coping, comprehensive family involvement in treatment is essential (Minkoff, 1987). Such a collaborative model needs to regard families as allies and partners in the therapeutic process (DeChillo et al., 1994; Furlong & Leggatt, 1996; Reinhard, 1994; Sommer, 1990) since providing information and knowledge can improve the capacity of family caregivers to provide care (Reinhard; Winefield, 2000). Collaboration can be defined as two or more parties working towards a common goal (DeChillo et al.). Families in general are more inclined to collaborate if they are informed, feel they are being heard (Grunebaum & Friedman, 1988; Winefield), treated with respect (Winefield), and their perceptions are integrated into treatment and discharge planning. Veltman et al. emphasize the importance of mental health professionals to emphasize the positive aspects of being a caregiver such as having a closer relationship with the individual in order to facilitate family coping.

Therefore, based on the experiences of families within the mental health system and the interaction of these experiences on the therapeutic treatment process, it is in the child's best interest to turn towards a collaborative model that includes communication, interaction, and the development of a working therapeutic alliance between not only therapist and child, but also therapist and parent. Thus the discussion now turns to the importance of the therapeutic alliance to treatment and finally to the related research of the alliance between the parents and their child's therapist.

The Therapeutic Alliance

Psychotherapy can be defined as a relationship in which the therapist and client work together towards goals through the focus on (1) the therapeutic relationship, (2) client attitudes, thoughts, effects and behaviour, and (3) social context and development (Brent & Kolko, 1998). This definition includes the elements of the social contexts of family, schools and service delivery, and development in psychotherapy, which Kazdin (1996) suggests are important in child and adolescent psychotherapy.

The relationship between the therapist and the client is described as the therapeutic alliance, which has emerged as a central focus in adult psychotherapy research (Hilliard, Henry, & Strupp, 2000; Soldz, 1990). Literature reviews have concluded that the strength of the alliance is related to outcome, however, a limitation is the failure to include child psychotherapy studies in the reviews (Shirk & Karver, 2003). The abundance of research in adult psychotherapy can be viewed as a starting point in determining what is relevant to the alliance in child psychotherapy (Digiuseppe et al., 1996). Recent findings by Hilliard et al. suggest that the therapeutic alliance in adult therapy may be impacted by both the therapists' and clients' early parent relationships.

There have been several definitions of the alliance proposed within the adult literature. One of the earliest definitions was that of Luborsky (Horvath & Luborsky, 1993). This definition defined two types of alliances: Type 1 and Type 2. Type 1 alliance, evident in earlier stages of therapy, is based on the client's experience of the therapist as supportive and helpful, with the client as recipient. Type 2 alliance involves a perception of the client and therapist working together and having a shared responsibility in the treatment goals.

The alliance is considered a significant predictor of improvement in adult therapy across different therapies (Barber, Connolly, Critis-Christoph, Gladis, & Siqueland, 2000). The consistent findings of the adult psychotherapy literature relating to the alliance and therapy success has been less consistent in child literature (Weisz et al., 1998). This may be because it is not the interaction of the child's alliance with the therapist alone which contributes to the process, but also that of the parents' alliance with their child's therapist. Thus, there is a need to focus not only on child-therapist dyad, but also other family members, whose relationship to the child's therapist may be critical to the success of treatment. "It seems self-evident that the impact of psychotherapy with children may vary depending on the extent to which significant others in the child's contexts (e.g., parents, teachers) are involved and supportive in the process" (Weisz et al., p. 78). This involvement may be enhanced by the alliance. However, before one can gain an understanding of how the parent-therapist alliance has an impact on the child's treatment outcome, it is first necessary to gain an understanding of how the relationship between the parent and their child's therapist is experienced.

Bordin's (1994) definition of alliance is considered one of the most influential models of therapeutic alliance (Digiuseppe et al., 1996). Bordin proposes a definition of alliance with an emphasis on collaboration which includes three components: goals, tasks, and bond. The first component, goals, are the agreed upon expectations for what is to be accomplished in therapy. Both therapist and client must perceive these expectations as relevant. Second, tasks are the techniques, procedures, or behaviours that are used to accomplish the goals of the therapy. Third, bond is the relationship or alliance that develops between the client and therapist. It involves the development of personal attachments that include mutual trust, confidence, and acceptance. This definition of the alliance has been applied to child psychotherapy by Digiuseppe et al. They define a positive alliance as "A contractual, accepting, respectful, and warm relationship between a child/adolescent and a therapist for the mutual exploration of, or agreement on, ways that the child/adolescent may change his or her social, emotional, or behavioural functioning for the better, and the mutual exploration of, or agreement on procedures and tasks that can accomplish such changes" (Digiuseppe et al., p. 87).

The difficulty with these definitions of the alliance and particularly that proposed by Digiuseppe et al. (1996), is that they place limitations on the application of the alliance outside of the dyad of the child client and therapist. As was previously discussed, the involvement of a child in therapy is viewed as a mesosystem in which the interactions of the child and his or her therapist are also related to the family microsystem and consequently to the parents. Since therapy is a multi-directional interaction, the parents need to be able to be included in definitions of alliance that are applied to children receiving therapy.

The alliance is an essential component in child therapy as it is in adult therapy (Lewis & Blotchy, 1997; Shirk & Karver, 2003). However, the development of the alliance differs in child therapy as the child does not come alone to therapy, usually does not refer oneself (Kazdin, 2000), and does not necessarily make the decision to terminate. Child therapy differs from adult in that therapy requires the coordination of therapist, child, and parent (Lis, Zennaro & Mazzeschi, 2001). This implies the important role that parents play in their child's therapy process and thus, the importance of the relationship between the parent and their child's therapist. The adult literature indicates that a strong alliance helps deal with the immediate pain of coping, helps postpone the desire for immediate symptom reduction, and that the client's perceptions of the relationship with the therapist as accepting and supporting is linked with a perception of the appropriateness of treatment (Horvath & Luborsky, 1993) and with a positive outcome (Barber et al., 2000; Conte, Buckley, Picard, & Karasu, 1994). A recent study by Barber et al. found that individuals with greater symptom improvement had a stronger bond and collaboration with the therapist.

A recent meta-analysis of therapeutic relationship studies in child therapy found that the alliance is related to outcome across treatment types and developmental levels (Shirk & Karver, 2003). The strength of the association between relationship and outcome was comparable to that of estimates in studies of adult therapy. Further, the association between the therapy relationship and outcome was relatively higher, although not reliably so, for parent-focused treatment (e.g., parent co-involvement, parent-management training) than for child treatment (Shirk & Karver).

Parents and the Alliance in Child Therapy

Several authors have emphasized that an alliance between the parent and their child's therapist plays an important role in the child's therapy process (Diamond et al., 2000; Lewis & Blotchy, 1997; Mufson & Moreau,1998; Piovano, 1998; Shirk & Russell, 1996; Siskand, 1997; Sperling, 1997; Steiner & Feldman, 1996). However, the importance of the parent-therapist alliance appears to be an unquestioned assumption as none of the authors cite supporting research. Siskand (1996, 1997) suggests that it is a neglected subject within the research literature. There has been little attention paid to the parent-therapist relationship in the literature (DeVet et al., 2003). In light of this neglect there are several conclusions drawn within the literature regarding the parent-therapist alliance. These conclusions include: the role of the therapist is to form an alliance with the parents and it is rare for a therapist to be able to treat a child without an alliance with at least one parent (Sperling; Siskand); an alliance helps parents to accept and address the child's problem and helps to alleviate tension and increase compliance (Mufson & Moreau; Sperling); the alliance aids to create and maintain a therapeutic environment for the child and helps parents understand the impact of their behaviour on their child (Lewis & Blotchy; Piovano) thus, reducing their expectation for quick fixes (Lewis & Blotchy); and finally, parent-therapist alliance facilitates the development of the child-therapist alliance (Piovano).

Parent Involvement and Child Therapy

Raney, Shirk, Sarlin, Kaplan, and During (1991, as cited in Shirk & Russell, 1996) found that children's perception of their parent's alliance with the therapist predicted the quality of the child's alliance with the therapist. This finding suggests that the parent-therapist alliance may contribute to the child-therapist alliance and that child therapy needs to be considered in a broader relational context. Fauber and Long (1991) suggest the possibility that the family will have a greater impact on the child than will the therapist in isolation and thus, the child's therapy is embedded within the context of relationships within the family. Focusing only on the individual child in therapy has shown limited impact (Weisz, Weiss, & Donenberg, 1992).

In the child psychotherapy literature there is a theoretical understanding of the need of a relationship between parents and the child's therapist, yet this remains unchallenged and rarely investigated in the research literature. While parents have knowledge about their child that cannot be accessed from other professionals (Sperling, 1997; Tarico et al., 1989) they have been relatively ignored by researchers. This is unfortunate since parents are involved in their child's treatment process as treatment needs to be multi-focused to involve important adults in the child's life (Kazdin, 1994). As well, parents have information regarding their child's progress, barriers experienced, impacts on the family, experience of external supports (Tarico et al.), and their expectations for change (Digiuseppe et al., 1996). Further, the child's problems are defined by the parent (Yeh & Weisz, 2001) and it is necessary to understand how parents define and understand the problem and what their expectations for change are (Leve, 1995).

Forty to sixty percent of families terminate counselling prematurely based on therapists' judgment (Kazdin, 1996; Wierzbiki & Pekarik, 1993). Parents ultimately make the decision to terminate the child's therapy (Leve, 1995) and when parental expectations are different from what actually happens in therapy the dropout rate increases (Pothier, 1976). Kazdin, Holland, and Crowley (1997) found that parents who terminate early are more likely to be socio-economically disadvantaged, a minority, younger, a single parent, and report harsh child-rearing practices. Most importantly, the researchers found that a poor relationship between the parent and therapist predicted early termination. Parents indicated that therapists who are able to display interest and warmth and develop a connection with the child are likely to have increased success (Stith et al., 1996).

However, the strength of the therapeutic relationship established between the parents and the therapist may be even more important to the success of therapy than the alliance with the child (Digiuseppe et al., 1996; Sperling, 1997) as it is suggested by Weisz and Weiss (1993) that factors related to the parent, not the child in therapy, are more related to dropout rates. Their analysis of the literature found that when parental expectations for treatment length and actual treatment recommendations did not match, there were higher rates of attrition. They suggested that this may be due to parents wanting shorter treatments. However, such findings may indicate more than this. It may also indicate a lack of communication between the parent and their child's therapist and consequently the parent not understanding their role or the goals and tasks of treatment. A study of parents' satisfaction of children and adolescents receiving inpatient psychiatric treatment reported that 67% reported that the treatment plan was not adequately explained to the parent, 72% felt it did not meet their child's needs, and 60%

did not feel the psychotherapist was professional and caring (Chung, Pardeck, & Murphy, 1995). The results of the study indicated that the parents felt that they should have had more contact with their child's therapist. Parents felt they were not involved or viewed as important and indicated that therapists were not responsive to their needs for communication such as by returning phone calls or providing opportunities to discuss issues face to face. Similarly, Stith et al. (1996) report that both parents and children indicated that the personality and behaviour of the therapist was essential to their positive experience in therapy. Thus, the therapist plays a significant role in parents decision to terminate treatment early and in the parents' experience of therapy. These studies seem to indicate that when parents feel they are not listened to and there is a weak parent-therapist alliance, treatment is more likely to end prematurely.

The need for a parent-therapist alliance is highlighted by the recent study of Garcia and Weisz (2002). These researchers interviewed parents following the ending of therapy for their child. Therapeutic relationship problems accounted for the largest percentage of variance for parents to prematurely terminate the child's therapy. Parents who ended therapy early were more likely to describe their child's therapist as not invested in either the child or parent, not competent, and not doing the right thing (Garcia & Weisz). The authors found that nearly a third of parents whose children were in therapy stopped therapy in part because the therapist talked about the wrong problems. Bonner and Everett (1986) report that the most frequent parental preference was for the therapist to demonstrate understanding. At the same time, if the therapist did not understand and target the problems most concerning to the parent, parental motivation to participate in treatment, or even to have it continue, may be threatened (Hawley & Weisz, 2003).

The importance of the parent-therapist alliance while the child is in therapy is often overlooked despite the fact that it is the parent who initiates treatment for their child, plays a role in goal setting and who ultimately decides to terminate (Digiuseppe et al., 1996; Kazdin, 2000; Leve, 1995; Shirk & Karver, 2003; Stith et al., 1996). Parents and therapists may have goals and expectations that differ from the child's (Digiuseppe et al.) and the child may not change to meet those expectations of the parent (Leve). Children and parents are found to relatively disagree on the target problems for therapy (Hawley & Weisz, 2003; Yeh & Weisz, 2001) with parents and therapist showing greater agreement (Garcia, Joseph, Turk & Basu, 2002; Hawley & Weisz). Agreement between parent and therapist increases when family is involved in treatment (Garcia et al.).

Meeks and Bernet (1990) suggest developing therapy contracts with parents to ensure an alliance, in an attempt to address parental fears of the homeostasis of the family being jeopardized: a fear which may interfere with the therapy process. As well, parents may also inhibit the therapy process for their child by placing limits on what the child may bring up in therapy or through physically terminating from therapy. The parent often has ultimate control in the initiation and maintenance of treatment and it is necessary to understand how their experience of the parent-therapist alliance influences the role they play in their child's therapy (Leve, 1995).

Diamond et al. (2000) discuss a model for building an alliance with parents in a family-based therapy for depressed adolescents. The authors propose five tasks involved in therapy with one of these tasks focusing on the alliance with the child and another on the alliance with the parent. Building the parent-therapist alliance focuses on exploring the personal challenges of the parent and the impact on parenting and the child (Diamond et al.). Diamond et al. build upon Bordin's (1979) model discussed previously and focus on developing a bond, goals, and tasks with the parent. The parent feeling supported and understood by the therapist facilitates the development of the parent-therapist alliance which is essential to increase parental participation in therapy and commitment (Diamond et al.). Diamond et al.'s perspectives are supported by DeChillo et al. (1994) who found that the perception of supportive understanding and the sharing of information with the therapist were associated with more frequent contact. Parents tended to be more satisfied with therapy when they experienced parent-therapist collaboration (DeChillo et al.).

Child Therapy Outcome Studies

Mu and Tomlinson's (1997) study of parents' experiences during a paediatric health care crisis concluded that parents experience helplessness when they feel their roles are taken over by health care providers. As well, parents perceive such situations as beyond their control, knowledge, experience, and ability. Similar experiences may result when parents bring their child to counselling as a result of problems being experienced.

Feelings of stigmatization, social isolation, and rejection from their external environment were experienced by parents whose child had been diagnosed with a conduct disorder (Webster-Stratton & Spitzer, 1996). The researchers found that parents felt judged by others who perceived their child's problems to be the fault of the parents, could be solved if the parent was more committed to parenting, or demonstrated more effective discipline. This study also exposed parents to videotaped parent training while their children received counselling. Parents progressed from feeling despair to hopeful, experienced a decrease in anger and guilt, changed their expectations for themselves and their child, and developed more effective coping abilities. These parents changed from assigning blame to understanding their child and the problems. They learned to accept their child and their own imperfections as parents.

The addition of parental involvement in treatment of obsessive compulsive disorder may be a necessary component (Knox et al., 1996). Knox et al. found that having no parental involvement had little or no effect in the reduction of obsessive-compulsive symptoms. Decreases were found in the frequency of compulsions once parents were introduced into treatment. Another study (Spence et al., 2000) compared CBT with social skills training for social phobia to groups with parental involvement and parental non-involvement in treatment to a waitlist control. Eighty-one percent of children in the parent involved condition compared to fifty-three percent in the parental non-involved condition were free of diagnosis of social phobia at twelve months follow-up. Bernstein, Borchardt, and Perwien's (1996) ten year review of childhood anxiety disorders emphasized that when discussing treatment recommendations for anxiety disorders there is a need for feedback and education to parents about the disorder and treatment plan.

A need for parental involvement is also demonstrated in studies of conduct. The current model of Multi-systemic Therapy (MST) (Multisystemic Therapy Services, 1998) acknowledges the role that parents and families need to play. Multisystemic Therapy

(MST) is an intensive family and community based treatment that addresses the behaviour of conduct disordered youth. The multisystemic approach views individuals as within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighbourhood) factors. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioural parent training, and cognitive behaviour therapies. Kazdin and Weisz (1998) concluded that MST is an effective treatment for conduct disordered youth.

A comparison of parent training to parent support for ADHD preschool children suggests training of specific behavioural strategies is necessary for change. While parent support is necessary it is not sufficient to produce change in the child with ADHD (Sonuga-Barke, Daley, Thompson, Laver-Bradbury, & Weeks, 2001). Parents need to play a role in their child's therapy that goes beyond being provided support and feedback regarding progress and instead need an understanding of the treatment plan and play an active role in implementation.

While the involvement of parents in interventions with children is becoming more common (Shirk & Russell, 1996) and surveys indicate that the majority of child therapists incorporate the family in some form into the child's treatment, efficacy in terms of the extent of family involvement has not been examined (Fauber & Long, 1991). Weisz et al.'s (1998) review of the literature stated that there is a need to focus on children and their families in treatment which has been neglected to date in the present research on child psychotherapy. Since parents are involved in treatment, to some extent it is likely that the process will have an impact on the them as well as on the child and on the interactions between them. This moves the focus from who attends therapy to the separate question of who is involved in and affected by therapy with children (Fauber & Long).

Despite these studies, relatively little is known about what parents experience when their child has undergone therapy. The difficulty with the Webster-Stratton and Spitzer (1996) study is that parents were exposed to videotaped training, thus they may have become involved in a process that differs from parents not provided such an opportunity. Tarico et al. (1989) focused primarily on parents' perspectives of the overall mental health system, not the child's individual therapist or the therapy process per se. In summary, it is known that parents have the control in initiation and maintenance of treatment for their child. An inadequate therapeutic alliance between the parent and therapist, and possibly perceptions of feeling blame for their child's difficulties, may provide parents with a sense of lacking control and helplessness, leading to termination of the child's treatment. It is necessary to develop an understanding of how parents experience the parent-therapist relationship when their child is in therapy in order to improve responsiveness and treatment to children and their families. Currently there are no published studies investigating the parents' relationship or alliance with the child's therapist (Devet et al., 2003).

Expectations

Most studies of expectations for therapy are on adult therapy (Arnkoff, Glass & Shapiro, 2002; Nock et al., 2001). However, parents' experience of the therapeutic alliance or relationship with their child's therapist is likely influenced by the expectations that they have for therapy. Kazdin (1981) suggested that early attitudes about a child's treatment impact investment in, and cooperation with, the treatment process. Expectations are the anticipations that a client holds about the behaviour of those participating in the therapy process (Bonner & Everett, 1986; Nock et al.). These expectations contain beliefs about any facet of therapy including procedures, outcomes, roles and the therapist (Nock et al.; Arnkoff, Glass, & Shapiro, 2002) and are viewed as determinants of how people behave (Tracey & Dundon, 1988).

Tinsley, Workman, and Kass (1980) initially operationalized expectations into four factors: a) Personal Commitment (self-expectations about motivation, openness to counselling, and responsibility in the process), b) Facilitative Conditions (expectations for acceptance, genuineness, trustworthiness, and confrontation), c) Counsellor Expertise (expectations for the counsellor to be knowledgeable, empathic, and directive) and, d) Nurturance (expectations for support and care from the counsellor). All factors have been replicated except Nurturance which has been subsumed under the Facilitative Conditions factor (Tinsley, Bowman & Barich, 1993).

Tinsley et al. (1993) surveyed therapists' views of the occurrence of unrealistic expectations in clients. Therapists viewed clients as tending to underestimate client contributions to therapy and overestimating therapist expertise. Such unrealistic expectations were viewed as detrimental to the therapy process. This study, however, is based exclusively on therapist views and there was no comparison of the therapists' views of clients' unrealistic expectations to actual outcome.

Throughout therapy expectations change so that they become more realistic with this change occurring through the changes in the therapeutic relationship (Tracey & Dundon, 1988). A study comparing Prochaska and DiClemente's (1992) stages of change with expectations when entering treatment found that clients' expectations of the therapist differ based on the stage of change they enter therapy in (Satterfield, Buelow, Lyddon, & Johnson, 1995). Similarly, Tracey and Dundon examined expectations at three points in therapy and found that expectations changed. Client expectations increased from the first to middle session and appeared stable until therapy ended. The increase in expectations was found to be associated with a positive outcome and presumed to be influenced by the therapist through the establishment of a therapeutic alliance. Tracey and Dundon suggest that the therapist influences client expectations to match those of the reality of therapy. Initial expectations are supported or refuted by the actual experience in therapy (Arnkoff et al., 2002).

Parent Expectations

There is little recent research found on the expectations of parents upon entering their child in therapy. The limited findings suggest that parents and children expect treatment to be more helpful than do therapists, that therapists view children's problems as more severe than parents, and parents' expectations for duration of treatment often differ from therapists' (Bonner & Everett, 1986). Expectations play a significant role in treatment participation, including attendance and completion and understanding this may be important to knowing if a child will even attend therapy (Nock et al., 2001).

Expectations are suggested to be a better predictor of the therapeutic alliance after the first session than therapist or client variables (Arnkoff et al., 2002).

Parent investment, and parent and therapist expectations are important components of treatment and predictive of child outcomes well after treatment ends (Nye et al., 1999). A study investigating parent expectations for school guidance counsellors (Paulson & Edwards, 1997) found that the expectations of parents were not necessarily similar to the roles that the average school counsellor fulfilled. Parents in this study expected counsellors to communicate and collaborate with other parties involved with the child such as the parents themselves, teachers, and other students.

In 2001, Nock et al. completed two studies focused on investigating parent expectations. The first study measured parent expectations for their child's therapy compared to pre-treatment parent, child, and family characteristics. Their findings indicated that parents from families with socio-economic disadvantage, ethnic minority status, and single parent families had lower expectations for their child's therapy and perceived therapy as not a credible resource. The older the child and the more severe the difficulties the lower the parental expectations were found to be, particularly for expected improvement of the child. Finally, parents with higher levels of stress and depression had lower expectations.

These findings led Nock et al., (2001) to then evaluate the relationship of these expectations as a predictor of premature termination of therapy, therapy completion, and perceived barriers to treatment. They reported that these parental expectations, influenced by parental socio-economic disadvantage, stress and psychopathology, and child severity, predicted perceived barriers to completing treatment, treatment attendance, and premature termination. In sum, parental expectations predicted whether therapy was completed, and the lower the expectations the higher the perceived barriers (Nock et al.). When Rey et al. (1999) asked clinicians to rate therapy outcome 10% of the clients were reported to have a negative outcome due to unrealistic parent expectations with the children of satisfied parents being more likely to be rated as having a positive outcome (Rey, O'Brien & Walter, 2002).

Parental satisfaction with treatment is important as satisfaction contributes to the continuation of therapy and may reflect parent expectations (Rey at al., 1999). Friesen (1992) reported a discrepancy between what parents rated as important and the frequency of such behaviours from professionals. Approximately 25% of parents experienced anticipated professional behaviours less often than they considered important with behaviours related to the relationship (e.g., honesty, supportiveness, parental involvement) considered very important by parents (Friesen). Rey et al. found that parent satisfaction increased for those who attended more sessions which may reflect an improved understanding of treatment issues which may be related to the finding in adult literature that expectations change as therapy progresses to reflect the reality of the experience (Tinsely et al. 1993; Tracey & Dundon, 1988).

Parental expectations have an impact on various potential outcomes of the child therapy process, beginning with whether the child will even attend. Parents are the ones who make these decisions and it is the expectations of parents that appears to influence the process. An understanding of parental expectations is needed to more fully conceive parental decision-making when it comes to a child in therapy as many end treatment early. Individuals in therapy have expectations regarding how each should act and the more these are congruent with the actual experience of therapy the more likely there will be a positive view of therapy as incongruence strains the therapeutic relationship making termination more likely (Tracey & Dundon, 1988).

History of Child Psychotherapy Research

In 1952 Eysenck concluded that psychotherapy was not effective and may even be detrimental to some people (Eysenck, 1952). This classic paper reviewing 19 studies which led him to draw these conclusions can be viewed as the beginning of psychotherapy research (Whiston & Sexton, 1993).

This prompted a similar evaluation of child psychotherapy. Levitt (1957) asserted similar results for child psychotherapy as Eysenck had concluded for adult psychotherapy. These disturbing claims led to a multitude of studies being conducted and a new interest in investigating the effectiveness of psychotherapy. In the area of child psychotherapy there have been four major meta-analysis identified in the literature (Weisz, 1997). From these meta-analysis it has been concluded and generally accepted that there is little doubt that psychotherapy for children is effective and helpful (Lis et al., 2001; Weersing & Weisz, 2002a; Weisz et al., 1992; Weisz, Weiss, Han, Granger & Morton, 1995). Weersing and Weisz, in a review of these studies, concluded that the main effects of these child psychotherapy meta-analysis fall within the range found for meta-analysis for adult psychotherapy and demonstrate fairly consistent positive effects for both the adult and child cohorts. In other words, child psychotherapy works as well as adult psychotherapy, and both are more effective compared to no intervention at all (Lis et al.; Weisz et al., 1995).

In a review of child psychotherapy research since 1963, Barnett, Docherty, and Frommelt (1991) summarized the previous 25 years as a search to verify whether child psychotherapy works. Since it has been relatively accepted that psychotherapy works research has turned towards comparing various treatment models and techniques. More specifically, Weisz et al. (1995) concluded that effects' sizes in child psychotherapy tend to be larger for adolescents than for children and for girls compared to boys. Differences are also found based on type of intervention. Weisz and Weiss (1993) compared behaviour to non-behavioural approaches to psychotherapy with children and concluded that overall behavioural approaches were more successful than non-behavioural.

Hundreds of treatments for children have been shown to have beneficial effects over the last 50 years (Weisz, 2000). Several conclusions are beginning to be drawn within child psychotherapy literature, one being that it can be successful however, this may be dependent on the therapeutic approach chosen with a favour towards behavioural interventions. The effect sizes found for behavioural therapies cannot be accounted for by methodological flaws (Lis et al., 2001). There are also many evidence-based treatments available for specific disorders such as anxiety and mood disorders, attention-deficit hyperactivity disorder, and oppositional and conduct disorders (Kazdin, 2002). This has contributed to the American Academy of Child and Adolescent Psychiatry developing clinical practice parameters to guide practitioners in best practice for specific disorders based on the available research (American Academy of Child and Adolescent Psychiatry, 1998).

Two limitations are identified by Weersing and Weisz (2002b) within the child literature. First, there has been an overemphasis on the disruptive behaviour disorders with less focus on mood-related disorders. Second, the relationship between the positive results in research trials has yet to be replicated in the actual therapeutic environment (Lis et al., 2001; Weersing & Weisz). This may in part be due to the reliance on measuring the outcome of treatment protocols in research environments which differs greatly from actual practice (Kazdin, 2000; Weisz, 2000). There is a need for future research to focus on developing and evaluating treatments within the practice environment (Weisz).

Kazdin (2000) identifies child psychotherapy research as hampered by focusing on answering the question "what works for whom." Kazdin (2000; 2002) views this focus as not only unfeasible but also a failure to recognize how parent, child, and other context factors influence outcome. More recently researchers and clinicians are beginning to call for a broader understanding of the underlying mechanisms of child psychotherapy and the contextual factors that may moderate outcome (Barnett et al., 1991; Kazdin, 2000; Kazdin, 2002; Kazdin & Kendall, 1998; Kazdin & Weisz, 1998; Lis et al., 2001; Weersing & Weisz, 2002a; Weisz, 1997; Weisz, 2000; Weisz, Huey, & Weersing, 1998). Kazdin (2000, 2002) states that the majority of research focuses on treatment techniques and a measure of symptom reduction with little consideration to other contexts, such as the parent or family, upon which these outcomes may be dependent. Further, Kazdin (2000, 2002) identifies the greatest weakness in this research as the lack of focus on understanding how or why therapy with children works. Focusing on symptom reduction alone may be underestimating the broad effects of child therapy (Kazdin, 2000). Future research needs to broaden the focus and move towards incorporating other contexts within a child undoubtedly exists (Kazdin, 2002; Shirk & Saiz, 1992). Little is known about what actually occurs during child psychotherapy (Shirk & Russell, 1996) or about how child therapy works (Brent & Kolko, 1998). Lis et al. concluded that the existing literature is only suggestive of what might be important in child psychotherapy and much more work needs to be done.

From the literature reviewed it is concluded that 1) families are embedded within a mesosystem of multi-directional interactions; 2) that parents have the ultimate control over initiation and maintenance of treatment; 3) that parents often feel judged, blamed, and not listened to by members of the external environment and mental health providers; 4) that as found in adult literature the alliance is important to successful outcome; 5) that the parent-therapist alliance is an unquestioned assumption and relatively ignored by child psychotherapy research; and 6) it is relatively unknown how parents experience the relationship with their child's therapist. Consequently, understanding these experiences in richer detail can improve the provision of treatment and services to children and their families.

Formulating the Research Question

The experience of parents is given little attention in the research in spite of the fact that children experiencing difficulties introduces stress into the family, and thus is an area requiring investigation. While it is contended in the theoretical literature that parents are important in a child's therapy, it is not understood how parents experience this involvement and this remains an unresearched concept. Therapy with a child cannot be viewed as a dyadic relationship between therapist and child; it is a situation of multi-directional interactions. The intention of this research project was to gain an understanding of parent experience of their relationship with the child's therapist moving beyond the dyadic relationship of child and therapist. Little is known about therapy with children from the parent perspective. It was hoped that this information would be helpful in understanding the impact the therapeutic process may have on parents and the role they play in the therapy process to potentially reduce the high rates of early treatment termination and increase the understanding of child psychotherapy beyond symptom reduction.

The Research Question

The preceding review and critique of the research helped to establish the rationale for the study which explored parents' experiences of the relationship with their child's therapist, and the expectations that parents have for the relationship and their role in their child's therapy. The primary research questions generated were:

1. What was the parents' experience of the relationship with their child's therapist?
2. What expectations, if any, did parents have of a relationship with the therapist and what role did they expect to play in their child's therapy?

CHAPTER THREE

Methodology

As discussed in the literature review the investigative approach used in the current study is qualitative methodology. The overall goal of qualitative research is to develop an understanding (Byrne, 2001b; Osborne, 1990) of the phenomena as the person experiences it (Colaizzi, 1978). The interpretation is intended to describe in terms of meaning (Fossey, Harvey, McDermott, & Davidson, 2002; Giacomini, 2001) and allow for the flexibility of evaluating experiences in a holistic manner (Byrne, 2001a; Moon et al., 1990) thus providing depth and richness to the understanding of experience. The goal is to describe and understand experiences from the participant's point of view without judgment (Webster-Stratton & Spitzer, 1996) and from the participant's perspective (Merriam, 2002).

As described by Merriam (2002) the qualitative researcher is interested in understanding how the participant makes sense of their experience through the use of the researcher as the instrument for data collection, interpretation, and understanding. Attempting to understand the experiences of parents from this perspective can be more clearly described as a basic interpretive qualitative study (Merriam) where it is sought "to discover and understand a phenomena, a process, the perspectives and worldviews of the people involved" (Merriam, p. 6). Merriam describes a basic interpretative qualitative study as involving the collection of data through interviews that are analyzed inductively to identify common themes or patterns. The present study used Merriam's basic interpretive qualitative approach as guiding methodology in attempting to understand how parents experience the relationship with their child's therapist. Rich descriptions of participants' experience contribute to a process that is inductive as it builds understanding and theory from the data rather than deductively using the data to test hypothesis.

A basic interpretative approach allowed the researcher to take advantage of the benefits of qualitative research by enabling the researcher to explore the participants' experience and develop an understanding of the commonalities and idiosyncrasies of the relationship between parents and their child's therapist. Colaizzi's (1978) approach to analyzing interview data and extracting themes was used as a guide to aid analysis and interpretation.

Rational for Qualitative Research

As Webster-Stratton and Spitzer (1996) observed, investigating parent experiences when a child is in therapy through qualitative methodology is a practical choice, since we cannot treat children successfully unless we know more about their family's subjective experiences of therapy. Basic interpretive qualitative methodology was used to investigate the phenomena in question. A basic interpretive qualitative approach allowed parents to provide a description of their experiences without the imposition of the preconceived theories of the researcher (Gall, Borg, & Gall, 1996).

As discussed in the literature review, since the importance of a parent-therapist alliance appears to be an assumption within the therapeutic literature, a basic interpretative qualitative approach has allowed for an illumination of this alliance from the perspective of parents through depth and detail. Investigations into such relationships require qualitative methods as there is a potential for exploring meanings and perceptions in relationships and the counselling experience (Street, 1996) and broad based inquiry into an area that is undocumented in other studies (Kidder & Fine, 1997). The goal of a basic interpretative qualitative approach was to increase the understanding of the phenomena of the parent-therapist relationship (Byrne, 2001a) as this appears to be an unquestioned assumption within the literature and little is known about how parents experience this relationship with their child's therapist.

The Pilot Study

A pilot study can aid the researcher to shape the proposed design through concrete experience rather than speculation (Locke, Spirduso & Silverman, 1987). It can allow the researcher to test questions, recognize areas that were previously unclear, and may provide insight into the shape of the study that had not been apparent (Janesick, 1994). Byrne (2001a) strongly recommends the use of pilot studies in qualitative research and states that pilot studies may contribute to the development of sampling criteria.

A pilot study was conducted prior to the development of this research study. It involved a 60-minute interview with one mother whose child had received counselling at a university-based counselling facility. The interview began with the broad open-ended question asking the participant to describe the experience of having a child receive counselling. Such a broad question was asked in order to inform the researcher of the salient experiences of the parent. Currently, relatively little is known about what parents with a child in therapy experience and a broad question allowed the researcher to gain a breadth of information to aid in the development of a narrower research question for more in-depth study.

The findings of this project highlighted the impact that a child in counselling has on a parent, including experiences of crisis, relief, positive and negative external supports, and learning to understand the child's perspective. Also highlighted were fears related to parenting and the importance of the therapist in validating the parent and thus alleviating fears. Finally, the parent-therapist alliance was highlighted in terms of its importance to the parent's experiences of counselling for their child.

The participant's child had received counselling over a two year period and with two separate therapists. Based on these two experiences the participant indicated that the relationships with each therapist had differed, one being more positive than the other. The participant felt that the first therapist did not listen to or understand her perspective as a parent and consequently the tasks he had her and the family perform were inappropriate. Counselling had ended with the goals unmet. In contrast, the relationship with the second therapist was perceived as more positive as the mother felt listened to and the therapeutic tasks were realistic and fit with the family.

The findings of the pilot project highlighted the importance of the parent's relationship with the therapist. It also indicated that a parent is able to discuss their child's counselling in relation to their experience and that an open-ended interview format adequately facilitated this process. Therefore, the present study utilized a qualitative method in order to develop an in-depth understanding of what parents experience when their child is in counselling. The broad question of the pilot study was narrowed to focus on the parents' experience of the relationship with their child's therapist.

Criteria Selection

The selection of participants needs to be relevant to the research question (Fossey et al., 2002; Giacomini & Cook, 2000). Purposeful sampling was used to aid in the selection of participants in order to select a sample that allowed for in-depth insights to be learned (Merriam, 2002). Purposeful sampling allows the researcher to choose participants who have experience with the phenomena being studied (Patton, 1990) and who meet particular criteria (Russell & Gregory, 2003). In choosing an adequate number of participants Morse (1998) suggests following the criteria of adequacy that she defined as data collection being completed when the researcher reached a point of saturation where variation was accounted for and understood. Byrne (2001a) and Fossey et al. describe data saturation occurring after the researcher has gathered enough data to allow for the development of themes that capture the participant's experiences indicating that the phenomena is represented by the data collected.

Parents who participated were those whose child had undergone therapy and were willing and able to share their experiences. The criteria for selection were: 1) the child had to have had at least three counselling sessions to ensure the parent had sufficient experience with the phenomenon; and 2) the parent had only one child in counselling to reduce the likelihood of competing experiences (such as success with one child or different expectations per child). Having more than one child in therapy may have led to difficulty with interpreting the parents' experience as therapy for each child would have its own process with various contributing interactions which would be difficult to compare to other parents with one child in therapy. As well, individuals whose child had only attended one counselling session were also eliminated due to concerns that these individuals may not have had sufficient experience with the phenomenon to provide a detail-rich description.

Seven participants were included in this study, six mothers and one father. These individuals account for six individual children; for one child both parents attended the interview. This couple's interview was analyzed as one unit. Participants ranged in age from approximately early thirties to mid-fifties. At the time of the interviews, two participants were single mothers, one divorced from her children's father and the other never married. The single male participant was the stepfather who participated with his wife, the natural mother of the child receiving therapy and both were divorced from their children's other parent. All six mothers who participated were natural parents to the child in therapy. The children ranged in age from six to fifteen and included two males and four females. All participants were Caucasian with family incomes ranging from $20,000 to $50,000 per year.

The children had been counselled by two male and three female first year doctoral students who were being supervised for their practice in the university-based clinic. One male therapist was licensed. The additional female therapist had a Master's degree, was licensed and practiced in a local family-oriented counselling centre. While this therapist's level of education differed from the others she was assumed equivalent in qualifications since she had completed the requirements for licensing while only one of the doctoral students was licensed. The personal identifying information of the therapists was not gathered in order to encourage participation as participants were concerned about information provided being used to evaluate individual therapists within the teaching environment. The presenting problems as reported by parents included behavioural problems, trauma, emotional problems, academic difficulty, and parent-child relationship problems.

Procedures

Ethical approval was granted by the Ethics Committee for the Faculty of Education. Participants were accessed through the university-based clinic that provides service to the public. To maintain counsellor-client confidentiality counsellors in the clinic were asked to contact potential participants to secure approval for the researcher to initiate contact. An advertisement was also placed in a local newspaper (See Appendix A). One potential participant contacted the researcher directly. Potential participants were contacted and provided with a detailed description of the study (See Appendix B). After determining that the volunteer met the participant inclusion criteria, the nature of their involvement and time requirements were discussed. Several potential participants declined once obtaining this information.

A mutually convenient time was determined for the interview. During both the initial phone interview and the taped interview, each participant was informed of confidentiality. A description of the study was reviewed orally and provided in written form to each participant upon first meeting. Participants were informed that all personal and identifying information was to be removed from the written study and pseudonyms used. In addition, it was reinforced that participation was strictly voluntary and that each had the right to withdraw from the study at any time for any reason. As well, it was highlighted that withdrawal from the study would not effect relationships at the clinic if the participant's child was to return in the future and that information would not be communicated back to the individual counsellors. After all questions and concerns were answered to the participants' satisfaction a Participant Informed Consent was signed (Appendix C).

Data Collection

The data collection involved two phases. First, the data gathering interview involved participants in a one- to two-hour interview. The interview began with the description of the study, also provided in writing for each participant to keep. Written informed consent was obtained prior to the interview. Structured interviews are inappropriate for qualitative research as they do not allow participants to express themselves freely and imposes the researcher's preconceived ideas onto the data (Giacomini & Cook, 2000). Merriam (2002) describes the semi-structured format as containing questions to guide participants to explore certain issues without the exact order or wording of questions being determined. The present study followed a semi-structured format beginning with the broad question asking participants to describe their experience of the relationship between themselves and their child's therapist. Participants were asked follow-up and probe questions from a semi-structured interview guide (See Appendix D). A semi-structured format allowed the researcher to focus the interview on issues that had been identified in the literature and pilot study as meaningful information regarding parent experience to access. A semi-structured interview also permitted freedom for the participant to discuss important issues of their experience that they determined to be most relevant and influencing. Techniques of active listening such as paraphrasing were used to facilitate self-disclosure and to clarify information to ensure the researcher had an accurate understanding of the participant's experience. The interview was used to permit understanding of the participant's world view without predetermining those points of view (Patton, 1990). Each interview was audio-taped and transcribed verbatim into text for analysis.

Following a preliminary analysis of the interview data and the resulting written synthesis, participants were provided with the written description of the analysis by mail. Each was provided with return self-addressed envelopes and a phone number to contact the researcher to provide feedback regarding the summary of their interview. The intent was to allow each participant an opportunity to clarify the information and to verify the validity of the researcher's interpretation. They were instructed to provide the researcher with feedback regarding the accuracy, misunderstandings, or misinterpretations made by the researcher. As well, they were invited to report any additional information they felt necessary to provide the researcher with a complete understanding of their experience. Three responses were received and three participants did not respond. Two reported through mail that the synthesis was accurate and representative. One was returned unopened as the participant had moved without a forwarding address.

Ethical Considerations

This research project followed the ethical standards and guidelines put forth by the Canadian Psychological Association as well as met those standards and approvals of research ethics at the University of Alberta. Specifically, informed consent was obtained prior to participation and participation was strictly voluntary. Each participant was provided verbal and written guidelines indicating that they had the right to withdraw at any time. Issues of confidentiality were addressed indicating that identifying information has been altered and pseudonyms are used in all publications and presentations that result from this study.

Participants who volunteered then signed a consent form (Appendix C) indicating that they understood the nature and purpose of the study, that all relevant questions had been addressed, and that they were willing to participate. To ensure the anonymity of the participants, signed consent forms were filed separately from the data. To ensure accurate interpretation of participants' experience, all interviews were tape recorded. Tapes are kept in a secure place, separate from other data, until seven years pass, at which time they will be destroyed.

Asking for personal disclosure of participants poses the possibility that issues raised could be distressing to the participant. It is imperative that the researcher be aware of this throughout the interview process. When issues of concern did arise, the participant was directed to several available counselling resources accessible in their area.

Data Analysis

A qualitative approach to analysis utilizes discovery-oriented, inductive logic (Merriam, 2002) for the purpose of allowing patterns to emerge without imposing pre-existing expectations on the data (Patton, 1990). Analysis and interpretation was intended to provide insight into perceptions and attached meanings of the participants' personal experiences. A basic interpretative qualitative approach (Merriam, 2002) was used with data analyzed using the procedures outlined by Colaizzi (1978). Several phases of analysis were involved, beginning with the audio taped interview that was transcribed verbatim to text. During transcription attention was given to participants' rate of speech, expressed emotions, tone of voice, and any emphasis given to specific words or phrases. Data analysis and collection often occur simultaneously rather than sequentially, allowing the data to reflect decisions made during process (Devers, 1999; Giacomini & Cook, 2000). Transcription began before data collection ended in order for decisions to be made regarding the gathering of further data and to determine when saturation was reached. An example of this process was the emergence after three interviews of the importance of the waiting room experience to participants, and consequently this question being added to subsequent interviews if not raised naturally by the participant.

Each transcript was then read and reread entirely several times to gain an overall sense of the participant's experience. Close attention was given to the manners of the participant's communication described above, as well as to repeated statements and the specific words chosen by the participant to express him/herself. This process allowed the researcher to become thoroughly immersed in the data. Next, excerpts of phrases or sentences that revealed aspects of the participant's experience were extracted from the transcript. Colaizzi (1978) refers to this process of extracting excerpts as "extracting significant statements." This information was recorded in a tabular manner. The next step involved paraphrasing the meaning of each excerpt in an attempt to clarify the underlying meaning. This abstract form of interpretation involved an attempt to understand the meaning of the excerpt for the participant. It is important during this step that "while moving beyond the protocol statements, the meaning he [researcher] arrives at and formulates should never sever all connection with the original protocols" (Colaizzi, p. 59). The goal was to develop themes from the excerpts without losing the meaning intended by the participant. The themes that emerged were then clustered together in an attempt to clarify the essential meaning of the participant's experience. The clusters of themes were validated by referring back to the original transcript to determine if they omitted or suggested anything not implied in the transcript (Colaizzi). The thematic clusters and themes contained within were integrated into an exhaustive description of the participant's experience of the phenomena. This is referred to as the within-person analysis.

After the within-person analysis of each interview was completed, a between-person analysis was then conducted in order to identify themes that are common to all participants. The clustered themes, or second-order themes, were compared across participants in order to determine whether there was anything contained within the original protocols that was not accounted for in the clusters of themes and whether the clusters contained meaning that was not implied in the original protocols. Each protocol analysis was reviewed in order to eliminate any unnecessary repetitions or irrelevant descriptions. Comparisons were also made to identify and highlight any unique features or themes that were not included in the clusters. The results of the clusters of the second-order themes were integrated into a detailed description of the phenomenon. Finally, validity of this description was attempted to be determined by having the participant verify if it accurately reflected his or her experience of the phenomena. Participants were given the opportunity to provide any additional information they considered relevant or that may have been overlooked. Three participants failed to respond to the question of whether the description was valid, which is a potential threat to the validity of the current study.

Validity and Reliability

It is important that the findings reported be able to be evaluated as plausible and believable (Byrne, 2001b). Validity and reliability are addressed in qualitative research in a variety of ways. According to Byrne different methodological approaches within the qualitative paradigm may have different terminology for regarding the evaluation of credibility but there are some commonalities. The primary ways for addressing the credibility of qualitative research are bracketing (Osborne, 1990), descriptive validity, interpretative validity, and theoretical validity (Maxwell, 1992).

Bracketing

Since the researcher is the primary instrument of data collection and analysis (Merriam, 2002), it is important to be aware of biases and potential impacts on the study (Byrne, 2001b; Devers, 1999; Moon et al., 1990). Bracketing is a process in which the researcher reflects upon and explores his or her own biases and preconceptions in order to "bracket their natural attitudes and to become aware of biasing preconceptions, so they do not impose them on their research participants" (Becker, 1986, p. 103). Through documenting experiences, perspectives and assumptions, and identifying personal connections with the topic the researcher reduces bias and enhances credibility (Byrne). Devers describes this as being internally reflexive where the researcher must consider the effects his or her own personal characteristics have on the findings by being constantly mindful of potential bias and the effect on results. The purpose of bracketing then is to increase credibility by becoming aware of, and continuously reflecting on, assumptions and beliefs that impact the research, which allows the reader to consider the researcher's role in the study (Fossey et al., 2002).

First, my research interests lie in the area of psychotherapy process. This research focus is derived from my assumption that therapy involves a process of change which I have explored through the literature reviewed and experienced in my involvement as a therapist. My experience as a therapist left me with the impression that the parent(s) must also be engaged and interactive in their child's therapy. Parents have expectations, goals, and agendas for counselling and experience successes and disappointments as a result of their child's progress.

Second, an understanding of family systems theories reinforces the presupposition that the parents and child constitute interactive parts within the family system. Essentially, these theories propose that a change in one aspect of a family system would affect other parts of the system (Bor et al., 1996; Nichols & Schwartz, 1995), each of which may be impacted by the child's counselling experience. Interviewing the parents about their perceptions is an extension of this orientation and explores the assumption that these interactions are multi-directional.

Finally, due to my own family experiences and those of being a therapist, I believe that parents often experience difficulties and struggles when their child is in counselling. These life experiences are what have led me to working with children as a therapist. My younger sister suffered from chronic mental health problems until her death by suicide. For several years her mental health placed my family in constant contact with mental health professionals. Through those years I not only went through my own experience, but I also witnessed the struggles that my parents encountered. These experiences have developed into an interest in parents and their families whose children are in counselling, an interest in working with children and their families, an appreciation of the importance of parents in therapy with children, and consequently this research project.

Descriptive Validity

Validity can be described in terms of rigor, credibility, trustworthiness, and believability (Russell & Gregory, 2003). Descriptive validity is concerned with the factual accuracy of the account of the participant. The subsequent categories of validity are dependent on this accuracy of the collected data (Maxwell, 1992). A threat to descriptive validity is the omission of relevant aspects of the phenomena that are significant to the participant's experience. To address this concern, interview length was adjusted for each participant so each could describe their experience in detail, and the interview questions from the interview guide were utilized to explore experience and perceptions of certain elements of the phenomena if not spontaneously mentioned. Participants were also offered the opportunity to provide additional information after the completion of the interview; however, several failed to respond.

Interpretative Validity

Interpretative validity is concerned with the accuracy of the interpretation from the participant's perspective (Maxwell, 1992). In order to address this issue interpretive accounts need to be grounded in the language of the participants and rely as much as possible on their own words. The interpretation and results presented were supported with quotations as original evidence in order to satisfy the reader regarding the connection between the interpretation and the data (Fossey et al., 2002; Mays & Pope, 1995). The interpretations were taken back to participants for confirmation of validity and accuracy and the participants were provided the opportunity to include any additional information they considered relevant or that may have been overlooked. This is referred to as member checking, which aids in the confirmation of the accuracy and validity of the interpretation (Giacomini & Cook, 2000; Janesick, 1994; Morse, 1998; Russell & Gregory, 2003). Given that three participants failed to respond to confirm the accuracy of the researcher's interpretation the researcher and reader should keep in mind the other aspects of validity when evaluating the trustworthiness of the current study.

Morse (1998) and Janesick (1994) suggest the audit trail which leaves adequate evidence of the raw data, data reduction and analysis products, and reconstruction and synthesis process. The audit trail provides the reader with evidence of the researcher's process of arriving at the interpretation. Byrne (2001b) describes the audit trail as including a research journal, original data (i.e., tapes, transcripts), communication with colleagues, and member checks. Throughout the current study these aspects of an audit trail were maintained not only as evidence of the decision-making process but also as a vehicle to facilitate interpretation.

Theoretical Validity

Theoretical validity refers to the researcher's theoretical understanding of the phenomena and the legitimacy of the application of the interpretation (Maxwell, 1992). Thus, theoretical validity depends on a consensus among those concerned with the research regarding the meaning and application of concepts to the phenomena. Therefore, it was necessary to evaluate the interpretation of the phenomena with the current theoretical perspectives about the therapeutic alliance.

Transferability

Maxwell (1992) defines generalizability as the extent to which one can apply the interpretation of a study to other populations or settings not directly studied. Denzin and Lincoln (1994) use the term transferability to describe generalizability. What these authors are addressing is the extent to which the present study will be able to describe the experiences of parents outside of the study's sample and be descriptive of the population (Devers, 1999). Generalizability, or empathic generalizability, refers to the extent to which the interpretation is found in the experience of others (Osborne, 1990). In qualitative research there are a small number of participants in order to explore a phenomenon in depth and thus, there is no attempt to generalize to a larger population. Instead, purposeful sampling and thick descriptions were used to provide the reader with enough information to judge appropriateness of applying findings to other settings (Byrne, 2001b). A study has generalizability if it provides usefulness to a reader in similar contexts (Russell & Gregory, 2003) and the researcher's role is to provide enough description so that the reader can judge transferability to one's own situation (Byrne, 2001a; Byrne, 2001b). Hence, it will be left to the reader to determine the meaningfulness of the research findings and whether they resonate with their own experience and relationship with the phenomenon (Fossey et al., 2002; Giacomini. 2001).

Reliability

Maxwell (1992) defines "reliability" as occurring when different observers or methods produce similar descriptions of the same events. Osborne (1990) describes reliability as consistency, replicability, and stability of measurements. In an attempt to maintain consistency, the same format, semi-structured interview guide, and procedures were used for all participants. According to Osborne, varying descriptive accounts are not necessarily threats to reliability as they can be obtained due to differences in theoretical perspectives and thus can be descriptively valid. There is no single correct way to formulate interpretations and many credible but different findings could emerge from the same data (Giacomini, 2001; Giacomoni & Cook, 2000). Devers (1999) suggests that replication from one researcher to another may not be possible in qualitative research and questions if this should even be a goal given the "socially constructed nature of reality" (Devers, p. 11). Reliability and consistency was maintained through clear descriptions of the data collection and analysis.

CHAPTER FOUR

Introduction to Participants

Seven participants who were willing to share their experiences of the therapeutic alliance with their child's counsellor were interviewed. Two participants were a couple who were interviewed together. Given that they complemented each other's perspective and description of the experience, they were viewed as one unit of analysis. Each interview began by asking the participant to describe their experience of the relationship they had with their child's counsellor. While following a general semi-structured interview guide (See Appendix D) the format was intended to be open-ended. It was not seen as desirable to create structured, predetermined questions or to report results in such a manner that reflected answers to specific questions. Each interview was audio-taped and transcribed verbatim to text. This allowed participants to relate and emphasize those aspects of the experience that they determined to be most relevant, impactful,or descriptive. The basis for the qualitative analysis was found within the texts.

A brief description of each of the participants was composed. Descriptions gave a sense of time and structure to the experience. These descriptions were presented to the participants, who were asked to comment and edit for accuracy, although not all responded. The following pages contain these descriptions that constitute the participants' stories. Pseudonyms of Kerry, The Johnsons, Shelly, Melanie, Leana, and June were assigned to protect their identities. Other personal identifying information of the participants, their children, and their therapists has also been altered to further protect privacy.

Kerry

Kerry was a woman in her 30s with two children: a son, Jeremy, for whom she sought therapy, and a daughter. Kerry was divorced from her children's father, and had since remarried. Kerry described her relationship with her ex-husband as lacking support towards herself and her children. Kerry and her family live in a small rural community outside of a larger urban community. Jeremy had behavioural problems, low self-esteem, and would not talk with his mother or his father or stepfather. At school he was viewed as a bully while at home Kerry often saw him sucking his thumb. The school was unable to manage his behaviour and he was placed in a behaviour modification class.

Kerry brought her 9-year-old son, Jeremy, to therapy when she was in a crisis situation and feeling she had run out of resources to help him. Kerry had been struggling with Jeremy's behaviour for several years and was feeling that she had no control over it. Spanking Jeremy was a turning point at which she realized that she was out of solutions and nothing had changed his behaviour. One day Jeremy stated to his mother that she had beaten him. Hearing her son say this frightened Kerry. She was distressed by the fact that she had resorted to spanking and decided to seek help.

Kerry participated in a parenting course with little avail and began to wonder whether Jeremy's behaviour was normal for a child his age. The decision to seek counselling for Jeremy was considered risky and a last resort. However she felt that she had no other choice but to go for help. Kerry sought therapy outside of Jeremy's school, even though services had been offered there. Kerry was concerned about being stigmatized and thus sought services outside of her immediate community. The family lived in what she described as a small, religious community. Kerry felt that her children were already stigmatized by the divorce and she did not want others to see that she was in need of help to manage her children. In addition to feeling like a failure as a parent, she feared how others would view her since she could not manage her child. The decision to seek services a long distance from where she lived not only carried a personal cost but also a practical one as she considered the pragmatics of organizing this weekly trip to the city on a limited budget.

Once Jeremy's therapy began a variety of emotions surfaced for Kerry. Letting another person delve into her child's emotions and problems was difficult. She feared what Jeremy might be saying and was concerned that he might come to hate her. She thought maybe Jeremy had been right about being beaten. Being viewed as a failure as a parent and having her parenting mistakes exposed was frightening to her.

Several sessions went by with no contact with the therapist. Kerry felt helpless and excluded and her fears continued. At times Kerry felt left out of the therapeutic process. She had expected to be provided more information by the therapist about what was happening with Jeremy and how she could help him. Eventually, she and her husband, Jeremy's stepfather, were invited to have a session alone with the therapist. While she continued to fear what the therapist may tell her, she also felt relieved and anticipated feedback. To Kerry's surprise Jeremy's therapist told her she was doing good things as a parent and that Jeremy's difficulties were not her fault. The therapist gave information and feedback about what she could do to help. Kerry began to feel more at ease which eased her tension and worry. Finally having a session with the therapist contributed to her feeling involved in the process. For the first time Kerry began to feel she had a connection and the beginnings of a relationship with her son's therapist.

Kerry felt validated as a parent when the therapist indicated that Jeremy's problems were not her fault. This was important to hear and helped her become more comfortable and less fearful of the therapy. She had been concerned that her parenting was somehow responsible for Jeremy's difficulties and she often wondered whether she had done something wrong. Once she had the opportunity to discuss this with the therapist she let these concerns go and began to turn her focus to how she could be helpful.

Eventually, Kerry began to trust the therapist. She felt less fearful and anxious and no longer paced the floor in the waiting room, worrying. Instead she began to think of her wait as her personal time, time when she could go for a coffee and read a book. It was that pivotal session where the therapist provided feedback to her that contributed to her feelings of comfort and trust.

Initially Kerry had expected Jeremy would learn tools to help him to be more successful in peer interactions and problem solving when angry. First she thought "Where is the man with the miracle?" While at first change did not seem to happen quickly enough, she soon began to observe more than she had expected. Kerry observed Jeremy getting along better with peers, making friends, and becoming eager to attend his therapy sessions. Observing these little changes over the course of therapy helped Kerry realize that change takes time and her expectations became more realistic as she focused less on fixing everything at once.

Kerry also identified unmet expectations. She and her husband had two sessions with the therapist over the seven months of her son's therapy. While this helped her to feel more at ease and validated as a parent Kerry felt that somehow she could be more involved in the process. She had expected to have more frequent contact with the therapist to be provided information on progress. Most distressing to her was that she was not receiving suggestions on how she could help Jeremy at home.

The therapy had an impact on others in the family besides Jeremy. His interactions with his sister changed. They began competing less for their mother's attention and began fighting less. The siblings also began to play together which they had not done well in the past. Jeremy's stepfather learned that he played an important part in Jeremy's life and previously had not realized that he had been like a father to Jeremy. Kerry felt this had a great impact on Jeremy and his stepfather's relationship.

Overall, Kerry viewed the role she played in Jeremy's therapy as small. Regardless, she made changes in her own behaviour in relation to Jeremy. She viewed herself as more flexible than she had been prior to the therapy, able to establish and maintain her authority as a parent and acknowledged that she was a good parent.

The Johnsons

Mr. and Mrs. Johnson were a couple in their 40s who lived in an urban community. This was the second marriage for both of them, and Mr. Johnson had two children from his previous marriage who live in a city several hours away. Both of Mrs. Johnson's children, Steve, for whom they sought therapy, and his older sister, live with Mr. and Mrs. Johnson.

The Johnsons described Steve as a 9-year-old boy experiencing behavioural problems in school, often refusing to participate at school, and defiant to teacher requests. He mostly sat in class with his head on the desk and the family experienced similar problems with Steve at home. Steve often withdrew from them making it more difficult for them to understand his behaviour and feelings. The Johnsons were worried that Steve did not know right from wrong. They often wondered what was wrong and why he behaved in the ways he did.

At the time of starting therapy the Johnsons were frustrated, angry, and had difficulty understanding why the school had not been able to help Steve who had been placed in a "special behaviour class." He had a reading disability and was frustrated easily. Eventually Mrs. Johnson began attending his class each day in an effort to help, but tired of her presence, school personnel asked her to stay home. This angered and frustrated the Johnsons who felt that no one was able to help and that they were out of resources. The Johnsons knew that Steve needed more than they could offer him. Steve had been seeing a private psychologist in the community but they could not afford this high cost and they began to feel resentful of their son. Mr. Johnson felt his anger rise as he reached the front door of home each evening contemplating what might have gone wrong that day. Mr. Johnson was frustrated with the constant phone calls from the school and he received calls almost daily at work which were interfering with his work performance. Dread and apprehension rose in him each time the phone rang. Eventually the phone calls stopped, not because Steve had changed but because the school gave up calling. The Johnsons felt that someone with more skills than they had was needed as they were ill-equipped to manage their son at home or school without assistance.

The Johnsons took their son to see the therapist for 16 sessions. Each Saturday Steve gave up his cartoons and his stepfather gave up his day to sleep late in the hope that therapy would help. Initially therapy did change the situation in the view of school personnel. The therapist went to the school to advocate for Steve and spoke with the teachers and principal. The Johnsons felt school personnel took a step back as it was clear that the Johnsons were trying to do something to improve the situation. This meeting with school personnel occurred within the first few sessions and was an important event for the Johnsons as they felt this school meeting with the therapist helped the school realize that things could not be fixed overnight. The Johnsons felt the stress began to lift and felt supported by the therapist.

The Johnsons were fearful for Steve's future as the consequences for his negative behaviour would likely become far worse and they were desperate to change it. The Johnsons' expectations for Steve's therapy included being given feedback and guidance about Steve's behaviour and being better able to communicate with and understand him. They expected to be told how to parent him more effectively and to be instructed on what changes to make at home. They expected to play an active role in treatment and in helping changes take place. Many of the expectations they expressed were for themselves and their parenting of Steve.

As therapy progressed the Johnsons began to feel disappointed and left out of the therapeutic process. No feedback, guidance, or new tools were given, and no change was observed. They felt the little feedback they were given did not address the problems. At the beginning of the process the therapist gave them an explanation of play therapy and how she was relating to Steve. They felt that this was not helpful as it was not useful at home and had no concrete value to them. While they understood that play therapy met the therapist's need of building a relationship with their son, they felt they needed more than that. The Johnsons thought that Steve's relationship with the therapist was only one part and the therapy goals needed to be broader to include them in some sessions so they could play an active role. Despite their disappointments they continued to take Steve to see the therapist and refused to give up hope for change. They were fearful to discontinue as they struggled with managing Steve's behaviour.

Eventually, Mr. and Mrs. Johnson began to question their expectations, and themselves, wondering if their expectations were too high. They made some adjustments when they realized "there was no miracle fix and you can not go click and have a perfect boy." They had what they called "wild expectations that someone was going to unlock his brain." They fantasized coming to therapy a few times and leaving with a normal 9-year-old boy. As they came to grips with the unrealistic expectations they still felt that more could have been done. They had expected that after a few sessions the therapist would sit with them and discuss what was wrong and how to handle it. They continued to wait and hope and as each week passed Mrs. Johnson felt herself become more disappointed as there was no change and Mr. Johnson had no new parenting tools. She was waiting and hoping to be told what to do and not to do, which never happened.

The Johnsons thought that if they had been more involved things would have been better. They were angry that the only involvement they had was completing forms in the waiting room. They began to feel there was no help and no light at the end of the tunnel. While initially they felt supported, their relationship with the therapist failed to develop further and became distant. The Johnsons reserved passing judgement on the therapist because they felt they lacked knowledge of what was supposed to happen and thus never questioned the therapist directly and remained silently frustrated and disappointed. They described themselves as outsiders as over four months of therapy they were invited to one session with the therapist.

Looking back, the Johnsons indicated that if they sought therapy again they would request more involvement. Despite this, they decided therapy had been the right choice but they needed a new therapist and to take a more active approach as parents. After sitting in the waiting room week after week, Mr. Johnson observed many parents being taken into therapy rooms and wondered why not him. While sitting in the waiting room helped Mr. Johnson to realize he was not alone, which was validating for him, it also increased his frustration level. He wanted to be one of the parents taken into a room by the therapist and to be involved. Eventually he began to relax during this time and felt relieved that even if just for an hour, someone else was responsible for Steve. While their attempt to address their son's behaviour was not successful the Johnsons are not going to stop trying and they recently sought a referral to another therapy service.

Shelly

Shelly was a woman in her early 30s who lived in an urban community. She was divorced from her daughter Kayla's father and was now living with her boyfriend and their new baby boy. Shelly described her relationship with Kayla's father as supportive and that he continued to play an active role in Kayla's life.

Shelly brought her 6-year-old daughter, Kayla, to therapy because she was suspicious that Kayla had been sexually abused by her current live-in boyfriend. Shelly observed Kayla's behaviour change dramatically during this time. She wondered if Kayla was abused or was having trouble adjusting to new family members, as she also had a new baby brother. Shelly was distressed to witness her daughter transform from a happy, bubbly, and confident 6-year-old to a girl with slumped shoulders who was irritable and weepy. She was concerned about the seriousness of her daughter's state. Shelly felt desperate for guidance and wanted to know if she should leave her current living situation.

Bringing Kayla to therapy was an easy decision for Shelly as she saw it as necessary for them both. However, Shelly had reservations about telling Kayla who they had an appointment with. Instead she told Kayla she was going to see somebody who wanted to know more about her. She did not want Kayla to feel embarrassed and it was not until later that Shelly realized it was she herself who felt embarrassed.

Shelly brought Kayla for three appointments with the therapist. Shelly's suspicions were confirmed when the therapist told her Kayla had been traumatized in some way but did not want to discuss the details and so felt there was nothing the therapist could do to help. Anger, shock and disappointment arose in Shelly as she felt guilty her daughter went through this process and was not helped by it but rejected. Feeling uncomfortable with the outcome Shelly consulted another therapist who implied that Shelly wanted to know what happened to Kayla to get revenge on her boyfriend. Shelly felt misunderstood and attacked and wondered why no one understood she just wanted to help her daughter. Shelly herself had been abused as a child and felt that she had life experiences that she could draw upon to help her daughter. She had hoped a therapist would guide them through that.

Shelly then sought treatment for herself. Again she felt misunderstood and left with the feeling that her daughter's trauma was insignificant. She felt she was being treated like she was just another casualty and labelled as a paranoid mother. Shelly's experiences with therapists were not helpful for her and she was confused. It was difficult to understand the mixed messages that while her daughter had been traumatized there was no help for them.

The expectations Shelly had for therapy were not met. She had hoped to be told what behaviours to observe in Kayla to know if something was wrong and how to help her. Shelly needed resources and tools to work with at home to communicate with Kayla. Shelly felt confused about the role she or the therapist should play and had thought her expectations for therapy were what psychologists do; they talk to kids, try to figure them out and help them. Shelly was angered thinking that if the therapist had worked with Kayla a little longer things would have been different, and that decisions had not been made in the best interests of her child.

Involvement in the therapy was limited for Shelly and she felt left out of the process. She was not included in any part of her daughter's sessions and it was not until the third and last session that she was invited in to speak with the therapist. The feedback provided did not meet her needs to help Kayla as she was not told how Kayla could be helped, only that she could not be. It was in this last session that the therapist validated Shelly's concern that Kayla had been abused and possibly traumatized. She was then told there was no point in bringing her daughter back to therapy again as she did not openly discuss the abuse. Hurt and guilt welled in Shelly as she consumed this information about her daughter. She felt confused—if there was something wrong, why was no help offered? Shelly wanted to feel supported by the therapist at this time. At the very least she thought if they were being sent home some recommendations or guidance could be offered. Nothing more was offered and Shelly left this last session feeling rejected, confused, and angry. At the very least she had her suspicions confirmed but this was not enough for her.

Following therapy Shelly wondered if Kayla told the therapist she blamed her mother as Shelly blamed herself. Shelly felt guilty her child had been left in a situation that left Kayla vulnerable and abused. Shelly desperately wished to have discussed these feelings with the therapist but their relationship was distant and Shelly had not felt comfortable to address her feelings.

The relationship between Shelly and the therapist was not collaborative. Opportunities for interaction with the therapist were not provided and Shelly did not feel supported as a parent. Shelly would have liked to have played a different role in her daughter's therapy as she felt she had information to offer and could have helped the therapist understand Kayla better. Instead she felt she was left out.

Disappointed in the process Shelly decided to never engage her daughter in therapy again as the experience was not as expected. Since therapy had not met Shelly's expectations she decided she had to help her daughter herself. She moved out of the home she shared with her boyfriend and gathered information and guidance from books to help her daughter heal. While Shelly lost her trust in outsiders to help, through her own resourcefulness she changed her role in her daughter's recovery. Shelly was disappointed the therapist did not acknowledge that as the parent she is the expert on her child and should have involvement in her child's care.

Melanie

Melanie was a woman in her mid-40s who lived in an urban community with her husband. Melanie sought therapy for her 15-year-old daughter, Kelly, because she was bullied at school. Seeing Kelly rejected at school was painful for Melanie and she dreaded picking her daughter up at school each day and seeing the hurt she was experiencing.

Melanie felt she had done all she could to change the situation as she had spoken with the teachers, the principal, the parents and the children involved. Melanie did not know how to help Kelly and neither did the school. She decided to take Kelly to see the therapist to help Kelly cope with being bullied at school.

Melanie seemed unaware that she entered her daughter in therapy with expectations, although easily described what she had anticipated. She hoped that the therapist would tell her she was a good parent as she feared Kelly's difficulties were her fault. Most important for Melanie was the expectation of having a good relationship with the therapist. She wanted to have confidence and trust in the therapist and felt relieved that these expectations were met. She feared that if such a relationship did not exist that therapy would not have gone well as she would not have felt confident that Kelly was in a safe place. Also Melanie felt Kelly would not develop a relationship with the therapist if she knew her mother did not trust the therapist. A working relationship between Melanie and the therapist helped Melanie to feel confident in reinforcing and following through on the therapist's suggestions and she felt eager to go home after a session to try any suggestions given.

The therapist validated Melanie's parenting and let her know that she made good parenting choices. This was important and helped alleviate Melanie's fear that Kelly's problems were somehow her fault. Melanie felt the therapist understood her and she was comfortable sharing her insights with the therapist.

The therapist met with Melanie and Kelly on several occasions, which Melanie felt was an important part of the process. Sometimes Melanie and the therapist met alone, and other times with Kelly present. Having regular contact with Kelly's therapist contributed to Melanie's feeling involved in the process and feeling she was aware of the goals. Melanie felt what she had to offer in these sessions was important and that she was listened to.

Being invited to sessions with the therapist was reassuring for Melanie. In these sessions she was able to judge the therapist's qualities and came to regard the therapist as insightful, warm and understanding. The therapist asked Melanie for her views and input and Melanie felt valued by the therapist. It was these interactions when Melanie was in the sessions that contributed to her feeling involved and supported. Melanie was able to develop a sense of satisfaction and comfort with the process even when she was not directly involved by being in the room.

The relationship between Melanie and the therapist helped them to make changes. Melanie felt that the therapist's guidance built Kelly's self-esteem and noticed that Kelly began to use some of the tools the therapist had taught her. Seeing Kelly change was like "the world lifted off my shoulders," and she felt confident things were going to work out well.

Waiting in the waiting room was another challenge for Melanie. Initially she wondered what Kelly and the therapist were doing in the session. As Melanie developed confidence in the therapist her experience changed. She began to forget about the sessions and focused on crossword puzzles instead. She discussed less with Kelly at home and would encourage Kelly to bring her concerns to the therapist. Melanie strongly felt it was the connection with the therapist that allowed her to feel this comfortable. Melanie felt a supportive relationship with Kelly's therapist would not have developed if she had been ignored as the parent and if not given opportunities for involvement, discussion, and provided guidance.

Melanie began to make her own changes and viewed Kelly's therapy as a lesson in letting go. Realizing she can not be there for every hardship, she stepped back and allowed Kelly to have her space and private time with the therapist. She no longer pushed for details of the therapy, and she felt Kelly was safe with the therapist. She decided Kelly had to be allowed to work things out herself. Melanie had mixed emotions during this process including grief that her daughter was growing up and pride in seeing her becoming strong. Melanie realized that her potential role would change as Kelly continued through adolescence.

Leana

Leana was a woman in her early 50s who lived in an urban community with her husband. Leana brought her 15-year-old daughter, Jane, for therapy for about 13 sessions as she had difficulty with Jane's behaviour at home. Leana had trouble communicating with Jane and had concerns about the appropriateness of her behaviour. Leana's concerns increased following a psycho-educational assessment where the psychologist recommended therapy for Jane. Leana wondered what was wrong with Jane and was extremely concerned about having caught her smoking marijuana in the house with the family at home.

Leana expressed expectations about how she thought the therapy would work. At first she did not think much of these expectations. She expected Jane to "discover the error of her ways" and to be "enlightened" as to how her behaviour affects others. She wanted Jane to be responsible for her behaviour and thought the therapist would tell Jane how she had been doing things wrong. She also had been expecting her relationship with Jane would improve and she wanted to feel closer to her daughter when therapy ended.

To Leana's surprise this is not what occurred as the therapist did not express dissatisfaction towards Jane for her behaviour. Leana expected the therapist to be directive with Jane and tell Jane her mistakes. Instead the therapist took a mediation role between Jane and Leana, helping them to communicate better. After the first few sessions together Jane was able to talk without interruptions from her mother and Leana was able to respond without Jane becoming upset. Leana had the impression that the therapist was supporting Jane so that Leana would stop and listen which helped Leana to stop arguing and listen more to Jane.

In spite of being involved in the early sessions, the relationship between Leana and the therapist was strained as Leana felt the therapist did not understand her views. The therapist told Leana that Jane's behaviour was normal and natural for a child her age and that Jane was trying to pull away from her parents. Leana did not feel reassured and questioned the therapist's morals and values, feeling they differed from hers. Leana struggled with this throughout the therapeutic process and maintained a sense that she was not heard or understood. At one point, however, she did address these differences with the therapist, who, while acknowledging her opinion, continued to disagree.

Leana began to doubt herself and thought that possibly Jane's problems were her fault and that maybe she needed to change. Leana started making conscious efforts to listen to Jane more and argue less, which started to improve the situation at home. The changes Leana observed were a subtle and gradual process that became noticeable near the end of the therapy. She noticed at home everyone was less uneasy when Jane was around. As family tension began to lessen they were less concerned something might set Jane off and were no longer walking on glass around her. Stress was alleviated for Leana as these changes occurred.

After completion of therapy, Leana indicated that the only change she would make in the process would be to start sooner. She had waited until things were "really bad" which was when Jane was caught smoking marijuana. Leana felt guilty because she thought some problems could have been prevented.

June

June was a woman in her late 30s who lived in an urban community with her husband. June brought her 8-year-old daughter, Sarah, for therapy for about 14 sessions over seven months because she had been having problems at school. June was struggling with how to help Sarah and blamed herself for the troubles. June described her daughter as having fears and worries and not acting herself. June feared Sarah lost confidence in herself as she had been having trouble doing her school work and often refused to go to school. At one point June and Sarah were fighting frequently and Sarah ran away.

June had difficulty providing rich and detailed descriptions of her experiences with the therapeutic process, often stating everything was positive. June stated she initially thought she had no preconceptions of what she expected of the therapy. When one of her expectations was not met she became aware that she did have expectations. She wanted to determine what was wrong with Sarah and expected the therapist would come to their home for the first appointment to assess Sarah. June felt home was where she had the main concerns and wanted the therapist to observe their interactions there. She thought if he came and observed for a week he could tell them what to improve on and how to fix it. June realized this was a misconception she gained from television and such observation was not necessary. June had been able to address this expectation with the therapist in the first session and he explained the process to her and what would likely occur. Having the processed explained helped her feel more comfortable and relaxed.

Over time June developed confidence in the therapist and felt comfortable. June felt she had been involved in the process and was invited to join some of the sessions with Sarah. During these sessions the therapist gave her feedback on what was happening in Sarah's sessions. Together with her daughter and the therapist, Sarah's goals and progress in therapy were discussed. June was provided opportunity to give input on developing the goals for therapy, which allowed for a relationship to develop between June and the therapist.

June considered the relationship that developed with the therapist was more than she expected in spite of her first expectation for a home visit not being met. Being invited to the sessions and having input as well as being given feedback helped build the relationship with the therapist and trust developed. While she felt it was most important that Sarah have a relationship with the therapist she was quite pleased that she too was able to know him well. Initially she had been sceptical of the relationship and how it might work out. However, the therapist helped her feel comfortable by inviting her to take part and listening to her views.

Throughout the earlier sessions June often wondered if there was something she and her husband had done to cause Sarah's problems. She viewed herself as Sarah's primary caregiver, and when she saw something happen with a child she wondered what the parents were doing. June begun evaluating her interactions with Sarah. She anticipated that hearing things about herself and her parenting may be part of the therapy process and she feared what she may hear. However June discovered from the therapist that Sarah's difficulties were not her fault. This was important to June and she felt validated that she was a good parent after all.

In light of this validation, June began to look more closely at herself and how this experience may impact her parenting. She wondered why she was not happy and began looking at how she and her husband had been interacting. Taking Sarah to therapy led June to start evaluating her marriage and her relationship with her children. June eventually began to see a therapist herself and she felt she had issues to discuss that were not necessarily related directly to Sarah's difficulties. As her therapy progressed her husband commented that she was becoming the person that he married. She realized how her unhappiness with herself had led her to treat others in her family negatively. Eventually it became easier for June to talk with Sarah and Sarah became more willing to talk with her mother. June became more conscious of how she herself felt, how this impacted her family and her interactions with them. Overall June felt that Sarah's therapy triggered a process of self-reflection for her that led her to feel better about herself and her relationship with her daughter.

CHAPTER FIVE

Results

The goal of the analysis was to develop themes from the parental interviews without losing the meaning intended by the participant. The following is a description of the themes which emerged from the analysis. The themes are intended to clarify the commonalities and differences of the participants' experiences. The themes were integrated and compared with the data and excerpts from the interviews are provided in order to provide support of the analysis to the reader.

Theme 1: Beginning Treatment

All participants began discussing their experiences of having taken their child for therapy by reflecting on the events, thoughts, and feelings that they had prior to initiating the process. While diverse in nature, these events and experiences played a large role in the decision of parents to refer their child for therapy. Each participant outlined how coming to the decision reflected on him or herself as a parent, how others both within the immediate family and outside viewed psychotherapy, and how this impacted the manner in which their child was perceived by others. Making the choice to seek help for their child was viewed as a last resort sought out of fear and concern about their child.

When relating the experience of having taken their child for therapy, all participants began their story with the difficulties their child was encountering either at home, at school or both. Parents discussed the difficulty of the decision-making process and the impact of feeling that they had no other options. Excerpts from the transcripts are provided in the participants' own words to serve as exemplars of their experience. Their excerpts are shown as indentations.

Being Out of Resources (Deciding What To Do)

Five of the six participants discussed feeling frustrated and not knowing what to do to help their child. Despite the differences in their situations, each indicated that the decision to seek therapy for their child resulted from feeling they had no resources left. Both Shelly and Melanie found it difficult to help their daughters who had become increasingly emotionally sensitive and were crying frequently. Shelly wondered if her live-in boyfriend had sexually abused her 6-year-old daughter, Kayla, and these suspicions caused difficulties in Shelly's relationship with her boyfriend. Shelly described how Kayla changed from a happy child to one crying all of the time. Shelly felt frustrated and alone as her boyfriend was not sympathetic. She consulted family and friends who were unsure how to help her but felt Kayla needed an assessment from a professional who would know how to address Shelly's concerns. Shelly felt helpless as no one was able to help her.

Melanie felt her 15-year-old daughter, Kelly, was a victim of bullying at school. Frustrated with the situation, Melanie had sought help from the school and other parents with no success and felt there was nowhere else to turn but to a therapist. Kelly had spoken to a school counsellor and teachers; however, no lasting changes had occurred. As Melanie describes her experience:

> I had gone the whole realm of trying to deal with it...I was at my last straw for sure because I had gone every place else, to the principal, the teachers and the

> kids and I thought now what? Because it would change for a week or two and then it would be back to square one. I thought, um, this isn't working. I need something more.

The decision to seek therapy was a last resort for all participants. The Johnsons were receiving daily calls from staff at their 9-year-old son, Steve's, school which was frustrating as they felt that school personnel should manage him. Mrs. Johnson resorted to going to Steve's class to keep him in line but school personnel soon requested that she discontinue this practice. She was frustrated by their action as she saw herself as wanting to help when no one else could. The Johnsons felt stressed, helpless and disappointed as Steve was already placed in a special learning school. Mrs. Johnson felt helpless and felt that if school personnel could not manage Steve, she would not be able to help him. Eventually school personnel suggested Steve be taken for therapy. As she elaborates:

> So I don't even know what to do as a mother because I know he is angry at the world. So I guess that is why I brought him to counselling. I need to communicate with him and figure out what I can do to make life better...For me it wasn't a difficult decision, we had to help him and in turn help us, yeah it was a frustrating year.

In a situation similar to the Johnsons, Kerry was struggling with managing her 9-year-old son, Jeremy's, behaviour. One event led her to refer her son for therapy: she spanked him. This was something Kerry had thought she would never resort to and felt that she was in a crisis state and unsure of what to do next as the strategies from the parenting course had not helped.

The decision was not totally straightforward for Kerry. Letting another person talk with Jeremy on such a personal level was an obstacle she had to come to terms with. Kerry feared what Jeremy may say to the therapist or what the therapist may tell her. Despite her reservations Kerry followed through as she had no other idea what to do. She felt helpless and unhappy with how she was handling the situation so far:

> I was at my wits' end and it was actually something I've never done in my life. It was that I spanked him that day, and I don't like that...It was that I had said if this happens again (spanking him) this is what is going to happen and the consequences were that this is what happened (counselling)...For me this was a last resort and pretty tough to let someone else to get into my child's emotions, it was very difficult.

Leana too had been experiencing difficulty managing her 15-year-old daughter, Jane's, behaviour. Leana caught Jane lying and smoking marijuana in her bedroom while her parents were at home. It was the brashness of these behaviours that led Leana to refer her child for therapy; however, it took some time before Leana followed through and made the referral. It was not until her daughter had a psycho-educational assessment and the assessor recommended treatment that she took Jane for therapy.

Initially several things interfered with Leana following through with her decision. Embarrassment and shame about Jane's behaviour made her wait. Leana felt guilty that as a mother she had not given Jane what she needed to make good decisions as reflected by Jane's behaviour. Once the psycho-educational assessment highlighted these problems and confirmed that Jane needed help she made the referral, but Leana continued to feel guilty that she waited:

> I wish I had done it earlier, instead of waiting so long until things were really bad. Mainly because we could have prevented some of it because I am still concerned about it... (Shouldn't have) waited until things were really bad. Not to be embarrassed or ashamed about it...I just wish I hadn't waited so long and I don't think the guilt ever goes away.

Fearing the Worst

Deciding to seek professional help resulted from the participants' concern and consideration about what was going on with their child. Except for Melanie, who was coping with her child being a bullying victim, the other five participants raised the concern that something was wrong with their child. Fear and guilt were common emotions as parents struggled with what could be the cause of their child's problems and whether they were at fault. Each parent noticed that the behaviours of their child was not the same as in the past and was different from how they saw other children the same age behaving.

For June, whose 8-year-old daughter, Sarah, was acting fearful and anxious about school, her explanation was as simple as "We sort of came because she was having problems. We wanted to determine what the problem was." June's perception was simple and straightforward; Sarah was having difficulties; therefore, the logical step was to seek help. June had tried talking to her daughter herself, but this did not work as Sarah did not want to talk. June decided to refer for therapy as she feared Sarah's sudden refusal to go to school and her nervousness could worsen without help. June did not discuss making the decision to refer for therapy as much as the other participants did, and she did not turn to school or other resources before referring to therapy. For June therapy was the only option she considered once Sarah refused to discuss any problems with her.

In contrast the Johnsons gave much forethought before they made the decision to seek therapy for Steve. They wondered what may be wrong with him and had trouble understanding his behaviour. One incident that stood out for them was when Steve collected money in the neighbourhood for charity, but instead of turning it in at school he spent it. The Johnsons could not fathom how Steve could not know that spending the money was wrong or that he may not be caught. It was events such as this that made it difficult for them to understand Steve and made them fearful of what his future would hold if they did not address what was wrong and help him:

> Part of the reason we brought him here was that he hadn't had that concept (right vs. wrong) and yes, at nine years he gets grounded for, but at 18 the consequences are far worse and if he doesn't understand that its going to escalate and that's why there are 14-year-old shooters and shit like that. And it scares the hell out of me...Yes, I want to know what is going on in his head, his mind.

The Johnsons feared the worst outcome given Steve's behaviour at such a young age. As parents they were afraid for Steve and their fearfulness increased their desperation to find out what was wrong. The Johnsons wondered if Steve's problems were related to his biological father with whom he had a conflictual relationship. Steve never lived with his father and they wondered if Steve was acting out for his father's attention or if he truly did not understand the consequences of his own behaviour. The Johnsons were aware that Steve had a learning disability and wondered if that could explain his behaviour. As they contemplated the possibilities that explained Steve they continued to feel confused and without answers.

Kerry also noticed changes in Jeremy as his behaviour became inappropriate and immature for his age which left her uncertain of what was happening. Kerry wondered if Jeremy's recent placement in a special learning classroom at his school was a cause as Jeremy's old friends were not in his class. Before the new class Jeremy had several friends and was happy and confident. As Kerry describes Jeremy:

> ...his self-esteem and his self image, things aren't normal for him or usual for him. I don't want to use the word normal, but weren't usual for him or his characteristics. He started sucking his thumb again...He started sucking his thumb and reverting to asking questions about telling him what he was like when he was a baby.

Kerry found it hard to hear Jeremy's unusual questions while he behaved in an immature way. Kerry avoided him at home as she was irritated by such behaviour. To cope, Kerry began having a 15-minute bedtime routine in which Jeremy was given the opportunity to talk with her although this did not change the behaviour.

Shelly identified feeling anxious and fearful of the changes she had observed in Kayla. Shelly was not sure of the cause of this behaviour, although she did have suspicions of sexual abuse. Shelly was noticing that she could no longer touch Kayla without a reaction. Shelly described the changes she observed:

> Normally she is very respectful and compliant. But she would, I would say OK it is time to go to bed and she would just slump and have a fit. Which totally freaked me out because she normally didn't act that way. Her shoulders slumped, her eyes were dark, and just crying. If you just touched her she cried and screamed you hurt me, you hurt me. She'd cry when you went near her. She started chasing her brother around with dirty diapers.

Leana pondered and feared what may be wrong with her teenage daughter Jane as it was becoming more difficult to talk with her and she was increasingly argumentative. Leana wondered how much was normal adolescent rebellion. As the school year progressed more phone calls were received from school personnel which increased Leana's concern as Jane's behaviours worsened. Jane did not feel a sense of responsibility to her parents and family which became more clear to Leana when Jane was caught smoking marijuana in her bedroom. Leana realized that some of this was adolescence, but drug use in the house was where she felt Jane crossed the line to more serious problems. To Leana, smoking marijuana in the house with parents at home was not normal adolescent behaviour:

> She was constantly arguing over everything, we couldn't have a conversation. She was missing a lot of school. She had a problem with telling the truth and she didn't feel she had any onus or responsibility towards me or my husband, towards her home or to her family...Things by the end of the school year were, they were pretty, we had gotten called in for her missing classes so we were getting pretty concerned.

Most participants found their child's behaviour unsettling, disturbing and confusing at the time they decided on therapy. They found their behaviours unusual and maybe even somewhat abnormal for their child. Fearfulness, anxiousness and uncertainty were common emotions identified by these parents as they struggled with the disconcerting behaviours leading to their seeking therapy.

Feeling Stigmatized

Three participants expressed feelings of shame or embarrassment from having to seek therapy for their child. Interestingly these feelings emanated from internal sources for each individual. None of the participants reported stigma being directly imposed on them by outside sources. However, one parent was motivated by her embarrassment to keep the therapeutic experience a secret, even from the child herself. The perception of stigma seemed to derive from the assumptions that parents held themselves about how taking a child for therapy reflected on them as a parent and on their child.

The most powerful source of stigma identified by Kerry was the perception that her community would look down on her for seeking therapy for Jeremy. She described her community as small and tight-knit, a place where everyone knows everyone. She viewed her children as already stigmatized by her divorce from their father. When it was suggested that Kerry see the guidance counsellor for Jeremy at his school she decided that it was better to go outside of the community to maintain confidentiality.

> We are from a small Catholic community where divorce is almost unheard of...and I think that maybe it (stigma) did at first (play a role) because I had to

> realize that I was a failure. But it's this school counsellor...I prefer to go outside of the school rather than have him pulled out of class when an opportunity arises.

For Kerry it was more than being stigmatized by divorce that motivated her to go outside of her community. Kerry viewed the need for therapy as her failure and felt embarrassed which led her to travel outside of her community. These internal feelings led to her need to hide her son's needs from her community.

Shelly was embarrassed and did not even want Kayla to know where she was being taken. Shelly had difficulty identifying where these feelings came from as no one had said anything to her about taking Kayla to see a therapist. Shelly lied to her daughter about the purpose of the appointment with the therapist. She had difficulty expressing why she felt motivated to keep this a secret. Her embarrassment was in part due to the nature of the problem being potential sexual abuse but also due to her own beliefs about how others would perceive the situation. Regardless, Shelly's embarrassment played a role in what information she gave her daughter prior to their first appointment. As she explains:

> I had told her she was going to see someone who wanted to know more about us. I didn't want her to know she was seeing a psychologist.

Contrary to Shelly, Melanie felt quite open about taking Kelly to therapy although her daughter did not share this outlook. Melanie was surprised that her daughter expressed embarrassment. Kelly did not want her mother discussing the therapy with anyone. Melanie struggled with how to handle her daughter's embarrassment. Melanie did not want to anger Kelly by telling others about the therapy but she also did not want

Kelly to feel that she should be embarrassed. Melanie wanted Kelly to feel that seeking therapy was OK and normal.

> Kelly was very, she didn't want another soul to know. Initially she was very embarrassed that she would have to go and see somebody. The stigma. I don't know where she got that from but I wasn't allowed to talk about it at all.

In an attempt to honour her daughter's wishes Melanie had few options for her own support during this process. She had found it helpful to discuss the difficulties with close friends and spoke with a friend whose daughter had also seen a therapist in an attempt to reduce Kelly's embarrassment. Melanie had Kelly talk with her friend's daughter, which helped Kelly feel less embarrassed by letting her know that others experienced this and were not embarrassed to talk about it. Knowing someone else had been through therapy normalized it for Kelly as her sense of stigma had been a result of her perception of what others would think about her if they knew she had been to see a therapist.

> I told Kelly there are different kinds of doctors that heal different kinds of things. So if you have a problem, we are going to deal with whatever the problem is and coming here to talk to somebody gives you another perspective and helps you to think about other ways to work through these problems. Also this friend also has a daughter who had a terrible time with a particular boy and I happen to know this boy so I understood and could shed a little more light for Kelly as this girl had seen somebody.

The stigma expressed by the participants was a reflection of their own perceptions and beliefs. Embarrassment was a common emotion based on the sense that others would not approve of their need for therapy and that therapy was a reflection of the individual's weaknesses or failures. Participants were fearful and embarrassed of what others may think about them if they knew they sought therapy although no one experienced direct disapproval from others.

Having Practical Challenges

There was one last challenge that these parents faced, regardless of their decision to take their child for therapy: the cost. The Johnsons took time from work to participate and therefore not only did therapy cost them financially, but they sacrificed income in order to ensure that Steve was provided for therapeutically. Kerry lived outside of the city so financial costs were accrued through therapeutic expenses and she worried how she would manage this financially.

> It was difficult to come for counselling although it (counselling) is free it costs for gas, the parking, a dollar or two for a treat afterward and a coffee, it ended up being an extra sixty dollars a month and with our budget, wherever and however we managed, and it was worth it.

Summary

The decision to take a child for therapy was involved and complex. With the exception of June, the parents in this study did not decide that their child needed something and then simply access it. There was much thought and contemplation as well as emotion included in the decision-making process. The feeling of having no other resources was common and was precipitated by frustration and a sense of their child being at a critical period. What naturally followed were questions attempting to make sense of their child's behaviour and whether there was something seriously wrong. Fear and concern were raised by the parents as they contemplated initiating therapy for their child.

Taking a child for therapy was a decision that not only affected the child but also the parents making the decision. None of the participants made the decision lightly, and each felt that it was an important one. Whether struggling with externalizing behavioural problems or internalizing emotional difficulties, the struggles of the parent were common. The experiences of these parents included frustration, guilt, fear, and helplessness. Each was faced with the fact that influential individuals in their child's life, including themselves, were unable to help. The decision to seek help was seen by all participants as a last choice when all other resources had failed. All but one participant had turned to at least one other resource prior to making a therapy referral including special classrooms at school, teachers, principals and guidance counsellors, friends, family and family support workers in the community. Deciding to take a child for therapy was not the first choice for parents with parents initially trying to deal with the problems on their own.

Feeling embarrassed or stigmatized by accessing therapy was common. This resulted from internal perceptions and beliefs including the fear that the child's need for therapy reflected on one's value as a parent and of being stigmatized by one's community. Understanding where a child's embarrassment might generate from was a surprise for someone who did not feel stigmatized herself, while another parent felt that the child should not know where they were going. Regardless, the concern for the child's welfare seemed to motivate the parents' behaviour and affect the experience in ways such as delaying treatment, travelling outside of the community, and lying to one's child about where they were going.

Theme 2: Having Great Expectations

The expectations upon taking their child for therapy varied from parent to parent with some expectations being common to most while others were unique. The expectations raised by the participants were not only about their child, but also about themselves and the therapist. Each discussed their preconceived ideas of what they thought would happen when they brought their child for therapy. A common theme was the emphasis parents placed on the expectations for what they themselves would experience by taking their child for therapy. These expectations are discussed below and excerpts are presented in indentation as support.

Feeling Uncertain

Melanie indicated that she had no preconceived notions of therapy. Neither she nor any of her family had ever experienced such a situation and so she thought she had no idea what to expect. In light of this initial statement she then went on to discuss what she had thought about and hoped for before therapy began. She thought that the therapist would help her daughter and her. She wanted the therapist to tell her she had been doing things right as a parent and help by letting her daughter know that. Melanie expected to have a relationship with her daughter, with Kelly's therapist and wanted to be involved in Kelly's therapy in some way.

> I really didn't have any preconception or any idea of what to expect. We had never been in this situation before. But in my mind I sort of wanted somebody that would help her through and hopefully I had been doing the right thing up to that point and maybe reinforce some of the things that I had been talking about because I talked ad nauseum.

Clearly Melanie did anticipate certain things. Melanie's ideas may not have been as clearly developed as that of other participants as she had trouble adding detail to her anticipations such as what a relationship with the therapist meant to her. Regardless, she did have some forethought about the upcoming therapeutic experience and entered her daughter into therapy with her own set of expectations. Melanie had expected for the therapist to help her daughter, help her as the parent, and validate her as a good parent to her and to her daughter. Melanie expected this process to improve the mother-daughter relationship. Finally, she expected to develop a working relationship with the therapist and for the therapist to involve her in the process.

Like Melanie, Leana began with the belief that she too did not have any expectations for what was to happen but quickly realized that she actually did have expectations. Her clarification of her expectations occurred when she realized the therapist was not seeing the problem from her point of view. She felt as though the therapist was working with Jane but not her. The therapist did not agree with her that Jane had problems and explained the recent marijuana incident as normal adolescent development. It was this explanation from the therapist that led Leana to realize that she actually did have expectations coming into therapy. Leana had never thought that the therapist would not agree with her. From the beginning she expected that the therapist would have seen Jane's marijuana use as a serious problem that was frustrating for Leana.

> I think I had expectations that I was probably unaware of before we started. She was very soft spoken and she listened well, and I think she tried to, maybe I got the impression she tried to back Jane up more, so that maybe I would listen. That did work...While it wasn't anything that wasn't helpful, the counsellor's attitude helped my expectations to change. She wasn't as concerned as I was so I wasn't sure what to expect after that. I thought maybe my perspective was wrong or maybe Jane is not being open or admitting things.

Feeling that her and the therapist's views did not match left Leana feeling that the therapist was on Jane's side and not hers. Able to see a positive outcome to the therapist taking this position as she began listening to her daughter, Leana began to question her own views of the incident. Leana had expected for the therapist to help her by validating her view of the problem to both her and her daughter. Leana felt confused when the therapist did not agree with her and this expectation was not met.

Neither Leana nor Melanie had been aware in the beginning that they had expectations for their children's therapy. However, both had sent their children anticipating that certain things would happen. Melanie discussed how she felt that she had not anticipated what was to happen; however, she had developed some ideas of what she wanted before starting therapy. Awareness of expectations was not evident to Leana until her expectations were not met. She began to question herself and her daughter and felt confused. Leana no longer felt confident of her own views or of her expectations of what she thought might happen throughout Jane's therapy as what Leana had expected did not happen.

Both Melanie and Leana were expecting to be validated by the therapist as good parents and for their children to accept this validation. Leana more specifically expected this to include the therapist's validation of her view of the problem. Both also expected to develop a helpful relationship with the therapist which for Leana meant having congruent views. Melanie expected the therapist to involve her in the therapeutic process although was unsure what role she would play. She did expect, however, that the experience of taking her child to therapy would improve her relationship with her child.

Having Expectations Met

Four of the six participants discussed whether their expectations had been met. Only Melanie felt that what happened throughout her daughter's therapy was what she had come to anticipate. Having a relationship with the therapist was the expectation that meant the most to her and without this she felt she would not have been able to proceed. The relationship developed over the course of treatment as the therapist periodically met with Melanie and her daughter. During these meetings, Melanie was provided information about progress. She also was provided the opportunity to provide feedback and ask questions of the therapist. Having the opportunity to engage in the therapeutic process was important to Melanie:

> I felt she was safe and was going where she needed to go. You really need to make that connection and you really need to understand each other. The worker needs to understand the parents and where they are coming from and requires that in order to work with the child. You can't ignore as a parent what goes on here and not discuss or help it, otherwise it will not develop.

Having a relationship with the therapist contributed to Melanie's feeling comfortable with her daughter's relationship with the therapist. In addition being involved in the process was important to her, both in session with the therapist and out of session with her daughter. Melanie felt that her point of view and contributions to Kelly's therapy were acknowledged by the therapist. Knowing that she was listened to and understood as a parent further enhanced her feeling that her daughter was safe and being helped.

Having Unmet Expectations

In contrast to Melanie, Kerry and Leana did not have their expectations met. Kerry had thought she would have been provided more information; however, the therapist did not meet with her for the first several weeks. Week after week went by and Kerry had no contact with the therapist other than dropping off Jeremy for the appointment. Having little involvement she began to feel fearful and insecure about what was happening in the sessions.

> I thought I would be more filled in. I thought I would be, I think the first month or so it bothered me that I didn't know what they were talking about in there.

While Leana had been provided information from the therapist and provided the opportunity to meet with the therapist on several occasions, she did not feel that the therapist understood her point of view. Leana expected when she brought Jane to therapy that the therapist would agree with her evaluation and understanding that there was a problem. Leana was concerned about Jane smoking marijuana and engaging in other behaviours that Leana considered disrespectful and unusual for a child her daughter's age:

> The therapist didn't see that as such an issue. So maybe that is just moral things that I have greater expectations for...I just think some of her (Jane's) behaviour, I am concerned about it and I don't think the therapist was as concerned about it as I was...And I never got the impression from the therapist that maybe that was the case. Jenn's OK, she's normal sort of things. It's just that that part was a big thing for me.

Leana found it difficult to move beyond this difference in perspective regarding Jane's problems, which impacted her relationship with the therapist, as she did not develop the sense of safety and trust. Instead Leana was not convinced or satisfied that the feedback given was an accurate perspective of her daughter's problems and began to question the morals and values of the therapist.

Expecting a Quick Fix (Where's the Miracle?)

For both the Johnsons and Kerry, there was the expectation that their situation would change quickly. They were experiencing a time in their lives as parents in which they felt they were in need of help and each anticipated that this help would be instant. As it is described:

> In my head I had a picture of the old man with the miracle. Then I realized what am I thinking? it's not going to happen like this. I started thinking realistically what can I expect from this. So I expected him to have more skills with the playground thing, for him to be able to come and with a new idea or whatever...Just a misconception that there would be an instant fix.

Initially Kerry expected that the therapist would have the solution to the problem that would then create immediate change in her son. As she realized that change is a process that takes time, her expectations changed. She saw positive interactions occurring between Jeremy and his therapist which allowed her to be more patient and realize that change takes time. She began to consider what was more realistic and developed more concrete goals for her son such as having increased social skills. Changing to concrete expectations gave her something to judge change against. She would be able to consider whether he was getting along better on the playground.

The Johnsons shared similar expectations to Kerry in that they expected the therapist to immediately understand their son, the problem, and make immediate change occur. They expected to be in treatment to resolve Steve's problems in several weeks.

> We were going to come here and maybe this is a wild expectation and they are going to unlock his brain there and work with him, help him, do whatever is necessary beyond being a first grader...Maybe I had way too high an expectation

> of what this was going to do for him. The ideal situation was to come here for six, eight or ten weeks and leave with a normal 9-year-old.

These descriptions by the Johnsons and Kerry highlight the expectation that treatment can be a quick fix, and that the therapist can fix the child. The Johnsons were disappointed by their son's treatment process as they had entered with idealistic expectations. While they also realized that their expectations may have been unrealistic, the expectations they held throughout treatment did not change, as they had for Kerry.

Expecting an Expert

While June had been quite pleased with the experience and relationship that she developed with her daughter's therapist, it did not come about as she had expected. When June phoned to make the first appointment she assumed the therapist would come to her home to observe them interacting at home. Initially, she was disappointed when the therapist instructed her to attend the appointment at the clinic. The manner in which June understood the situation was if the problems were in the home, it would be logical to deal with them in that environment. After an explanation from the therapist on the phone June was able to understand the therapist's point and attended the appointment as scheduled at the clinic:

> Well we had been hoping the counsellor would come to the house and see us at home because that was where we had the major concerns and he said no you need to come here and we did because we understood that...It was just felt like come and see us, observe us for a week and then tell us what to improve on. Like you see on TV.

June initially had expected the therapist to observe the family, identify the problem and tell them what to do to quickly solve the problem. She had viewed the therapist as an expert. Through a discussion with the therapist she was able to modify this expectation and was willing to meet with the therapist at the clinic. June felt comfortable with this resolution once the process had been explained to her by the therapist at the time of setting the first appointment.

Shelly also viewed the therapist as an expert. Shelly was disappointed as the process did not meet her expectation for the therapist to tell her what was Kayla's problem. Shelly felt that if the therapist had tried harder or spent more time with Kayla the therapist would have been successful. However, her daughter did not disclose to the therapist and Shelly was not given answers, which disappointed her.

> My expectations I guess was that these people are trained and they know how to talk to these children and they will find out what the problem is and when we know what the problem is we can deal with it. And they didn't...isn't that what psychologists do they try to figure out what is wrong with this child, what is bothering this child? I just felt a little more work could have been done, but she (the counsellor) obviously didn't feel that.

Shelly viewed the therapist as an expert who could provide answers and solutions and was frustrated and disappointed when the therapist did not live up to her perception. She could not understand why she was at least not given more guidance or any resources or tools to fall back on. She had wanted answers to Kayla's problems and when this could not be provided she at the very least expected other sources of material or guidance to support her with Kayla's difficulties:

> ...maybe they could have worked with her, told me how to talk to her, Ok there is a definite problem here, she has low self-esteem go out and read this book or do this. Tools that I could take home and work with...just how to deal with my child, more information. I'm sure there are things my daughter said, here is some resource material or look here, here are some tools you can help with her.

Shelly clearly wanted to be more involved in the process and to be provided with tools and guidance. She wanted the therapist to take the role of telling her what to do. She wanted to be told how to fix the problem even if she could not be told what the problem was. Like Kerry she wanted more information and guidance for at home and had expected that Kayla's therapy would have provided this. The feedback given after three sessions was that Kayla would not benefit from therapy as she was not disclosing to the therapist. Shelly disagreed with the therapist's decision to discontinue therapy and was dissatisfied and disappointed with the therapeutic process. The message Shelly took from this experience was to go home and live with it, a very disappointing outcome.

> It was a very empty feeling and after I became quite angry about it. I thought I paid for that. I paid for her (the counsellor) to tell me that she (my daughter) was traumatized and then not do anything for her. That was the diagnosis. It was just like I felt really disappointed...I was very angry about that because it wasn't in the best interests of my child.

As her words describe Shelly felt angry and disappointed that neither her nor her daughter's needs had been met. Shelly left this experience with no more information than when she began it. Despite not understanding what was wrong Shelly wanted guidance on how to manage and help the situation. She indicated that she did not feel supported as the parent.

The Johnsons shared the experience of disappointment as they had wished for more information and feedback from their son Steve's therapist. The Johnsons had been hoping to be involved in some of the sessions with the therapist so that they could learn how to interact with their son. While the therapist did meet with them periodically, they were not provided with tools or guided as to what they could do or change at home. Joint sessions with their son's therapist involved the therapist explaining her therapeutic approach and how she was building a relationship with Steve. This was not found to be helpful:

> I would liked to have been on some of the sessions so that she could see how I talk to Steve. Bottom line is that you can't go to a counsellor for the rest of your life, well, um, I needed to be able to know what I can do because I am with him. I need to know what I can do to help him get through this time...she explained how she was relating to him through play but nothing of concrete value that I got out of it so that I was able to say I can use that. Or I'll try that or anything at all.

Clearly the Johnsons were expecting Steve's therapy to be concrete and practical for them. The therapist's description of play therapy did not fit such an expectation as they felt unable to learn or gain anything directly as parents from the approach. The

Johnsons were feeling desperate in their need to help their son which was exacerbated by their perception that they did not have the required skills to parent Steve adequately. Communication was a problem between them and Steve as he often failed to respond to their attempts to engage with or discipline him. They were hoping the therapist would coach them about more effective parenting techniques by telling them what to do and what not to do.

> We needed someone with more training than we have to delve into this kids mind and help us to communicate with him to say here look this is what you are doing and you can't do this you have to do this...I was looking for a way to deal with Steve or communicate with him in a way to understand what was going on for him. We want to help him. And I think we didn't get any of this. Yeah we met with Sasha (counsellor) on a few occasions, and on one occasion we met with her without Steve at all. She never gave us any guidance on what we could do. Never.

Like Shelly, the Johnsons viewed the therapist as an expert who would know the problem and give them concrete ideas of how to manage behaviour. Not having the expectation met for such guidance and feedback was disappointing and added to their frustration over the five months of therapy. More disturbing to them was that they received no feedback from Steve either as he remained quiet after sessions, returning home to watch TV and continue with life as usual, leaving them unsure whether he was benefiting from the therapy process. After each session he showed them pictures he drew or things he made in session with the therapist which further frustrated them as they could not understand how this would help. As far as the Johnsons were concerned, he could have done that at home.

> Having come here and sat here for as many weekends as it was a lot of it, or the conversation on the ride back home was what he did in the play time, which would be the whole time. Now again, I am an outsider. I am sitting here in the lobby while they are in there doing whatever they are doing. All I hear about is that I made this or did that and I think gee you could have done that at home. And I guess there was never any feedback. Sasha never came to us and said look here is a way to deal with this or here is a way to get around that. I don't know if that was her role or not anyway.

Questioning Expectations

The lack of involvement as parents left the Johnsons feeling excluded and detached from the therapy process. As things progressed they began to question whether their expectations were too high and if they had anticipated too much. The desperation they felt for their son's welfare drove them to continue to bring him for therapy in spite of their frustration, and they continued to hope that they would get what they needed and wanted. They seemed unsure of what role the therapist should play and began to question themselves:

> I kept hoping. Everyone hoped. She's just building rapport, that's what she's doing and maybe it will be today. And I kept hoping, If I wasn't at that session and his stepfather had taken him I waited for him to come home and say this is what Sasha told us we need to start doing. And then it just never happened...The

> fact that we didn't accomplish the expectations that we did have, I still think that we did the right thing by bringing him here. I wonder if we looked for too much...maybe again my expectations were too high.

While Leana was surprised to see some changes in Jane, since she had not seen eye to eye with the therapist, these changes led Leana to question herself and whether her expectations were too high. Leana wondered if her expectation for the therapist to agree with her perception of the problem was unreasonable. However, even as her daughter changed Leana continued to remain unsatisfied with the therapist's assessment of the problem and remained unable to resolve this issue. As she describes her feelings:

> I wasn't really reassured. You know someone telling you oh no she's got a good head on her shoulders, she never thinks things through. I never see that, so for somebody to tell me that and from what I see just doesn't match up...we did see changes in Jane so I thought maybe it is me! Maybe my expectations were too high. I'm still not sure. I am still just watching and waiting.

Summary

While all of the parents were not consciously aware that they had expectations for their child's therapy, each participant discussed at least one. Even those who felt they had a positive outcome from the therapy had expectations that were not met. Even though there seemed to be an emphasis on discussing unmet expectations this did not seem to mean that parents had more unmet than met expectations. Rather parents seemed to be more aware of an expectation when it was unmet as it then began to play a prominent role in their internal dialogue. Parents also seemed to change some expectations once they gained experience with the therapeutic process. Actual exposure to therapy as well as discussions with the therapist contributed to expectations shifting. Parents who experienced a shift in their expectations seemed more likely to perceive the therapeutic experience as positive. Most detrimental to the parents' sense of satisfaction with the process was the interaction, or lack thereof, with the therapist. While each participant had different levels of involvement, all had expected to achieve something from this involvement. Parents wanted to know how they could contribute to their child's therapeutic process.

Parents entered therapy with the expectation that the therapist would have similar perceptions of the problem. Parents whose views matched the therapist's felt safe and reassured and were more able to develop a helpful relationship with the therapist. Feeling that the therapist misunderstood the parent interfered with this relationship and the development of a sense of trust.

Common to all parents was the desire for guidance and feedback from the therapist. Those who received little of this, or at least not the kind of feedback they anticipated, were frustrated and disappointed. Parents also viewed the therapist as an expert, which led to the expectation that the child's problems would be solved in a quick and efficient manner. To the dismay of some, having a child in therapy was either a process providing little change over a long period or, more distressing, one that provided no help.

Throughout the therapeutic process participants re-evaluated the situation within the context of their child's progress. Having expectations not met led most to question their preconceived ideas. Questions were raised as to whether parental expectations were too high. While this appeared to be an important issue for all of the participants, none of them discussed their unmet expectations with their child's therapist.

Theme 3: The Parent-Therapist Relationship

Having a Role

There were several similarities presented within the parents' experience both for those who felt a helpful relationship was present and for those who felt it was not. June, Melanie and Kerry described the relationship they had with their child's therapist in positive terms. June and her daughter's therapist met fairly regularly as the therapist sought June's input regarding what happened at home between sessions and also provided June with feedback. The focus of this communication was to track and to continuously re-evaluate progress and treatment goals. June and Sarah's therapist had developed a relationship through having regular contact and involvement.

> Well he wanted me to come in with some of the sessions and my husband as much as he could. And he would tell me what was going on in the sessions. It was pretty good and we communicated about the sessions.

Through the interaction June felt she learned to understand her daughter's difficulties more. The therapist provided explanations for Sarah's behaviour and guidance on how to handle it. June learned that Sarah's anxiety stemmed from a negative experience with a teacher who frightened Sarah and this new perspective helped June to understand Sarah and to know how to help when problems arose. The knowledge June gained from communication and interaction with the therapist allowed June to learn to understand and help Sarah better.

Throughout the therapeutic process June never felt left out or that there was more of a role she could be playing. June played an active role in developing and evaluating goals and treatment through open communication and regular contact with Sarah's therapist, which contributed to her developing confidence in the therapist. Initially June had been sceptical of how she would interact with the therapist, and so the depth of the relationship with the therapist surprised her. The relationship was focused on developing and tracking progress goals, helping June gain an understanding of her daughter's problems and how to help. Through the medium of regular and open communication and trust June felt a helpful relationship developed that facilitated the meeting of goals and treatment process.

> We just developed a confidence in him. We were compatible and had confidence in him. You have to have that confidence in him. I was sceptical, but then we came in and thought this is going to be good and we got to know him and he got to know us. We found we could share with him, be an open book.

Like June, Kerry was included in a few therapy sessions with her son, Jeremy's, therapist. Some involved both her and her son while others were with her alone. She found it comforting that his therapist would meet with her for a few minutes prior to the session with Jeremy beginning. Such meetings allowed Kerry to provide the therapist with information about what was happening at home, how she saw therapy going and the opportunity to ask questions. This component to Jeremy's treatment was important to

Kerry as being involved with his therapy reduced her own level of anxiety. Initially Kerry felt quite anxious as it took several weeks before the therapist began to communicate with her and involve her. As she describes it:

> We had these two really good sessions and I felt more comfortable after the first one. I felt comfortable, comfortable to the point that I was no longer thinking about what they were talking about in there. I mean I still wonder what they were talking about today. But there was less anxiety and worry...I started to feel at ease after that (feedback) session. But up to that point, I felt ease after that.

Being involved had an emotional impact on Kerry. When excluded from the first few sessions, she experienced anxiety and worry. She had trouble getting her mind off of what was happening in the sessions. Until the point of being included, the nature and process of therapy were unknown to her and she felt fearful. Once Kerry finally met with the therapist she was not told specifically what was being said but was provided with an opportunity to be included as a parent. This experience allowed her to feel comfortable with the process and trust the therapist. Kerry felt that she had the opportunity to develop a relationship with Jeremy's therapist and contribute to his improvement. It was not until she had been provided opportunity for involvement and communication that she began to develop a level of comfort and trust with the therapist, which then allowed the development of a relationship.

Melanie had a similar experience as those previously discussed. What was different for Melanie was that she expected to have a relationship with the therapist and to be involved in the therapeutic process. Melanie felt that if she had not had the opportunity to discuss her perceptions with the therapist then Kelly would not have participated and would not have trusted the therapist. Melanie saw her role as laying the foundation for Kelly and the therapist to be able to work together.

> If I hadn't first of all talked to her (counsellor) and laid some ground work she (her daughter) would not have been forthcoming on those things. Kelly (daughter) was sitting there when I was talking to her, she knew the things I had said much to her displeasure...I don't know how I would have been able to discuss with Kelly and reinforce the things that the counsellor had been saying if I didn't believe in her. Kelly knows me like a book. If I didn't have faith in counsellor she wouldn't have and I wouldn't have had to say anything.

Clearly for Melanie, the connection with the therapist was necessary from the beginning. She viewed it as the basis from which they would work. She expected she would play an important role in the relationship that her daughter would develop with the therapist as well. If Melanie did not have a helpful relationship and trust the therapist she was sure her daughter would not as well. Like June and Kerry, Melanie was involved in both individual sessions with Kelly's therapist and some with the three of them present. The involvement and relationship contributed to Melanie's feeling that the therapist understood the parental perspective:

> ...she wanted to discuss things with me and so she discussed one on one and with the three of us. It felt very productive because I could say things, because I never said anything to the counsellor that I didn't say to my daughter. So it was good that we had the rapport and so she understood where I was coming from.

Being involved allowed Melanie to develop a sense of confidence in the therapist as June had. As Melanie's confidence and sense of trust in the therapist developed, Melanie became less actively involved in the sessions. The sense of trust allowed her to feel that the therapist and Kelly would be able to work through the problems. Similar to Kerry, Melanie was able to feel less anxious about what was happening when she was not in the session once she had been given the opportunity for involvement.

> I was talking to the therapist and almost immediately developing a good rapport and a confidence. I just felt really sure that my daughter was safe here. That was very important to me. I would say that that had to be first and foremost. I thought I don't know what I am going to do if I don't connect with this person if we she don't seem to understand...probably over time I also developed a confidence in the therapist and thought she will take it from there. That pretty much sums it up. I had confidence in the two of them being able to sort things out.

Having a role and being involved in the child's therapy was important for parents. This involvement was described as including opportunities to meet with the therapist both alone and with the child. Parent-therapist interaction was bi-directional in nature where the therapist provided feedback to parents and parents provided feedback and addressed concerns with the therapist. This interaction contributed to reduced parent anxiety, worry and fear and led to the development of trust and confidence in the therapist and the process. Parents felt understood and felt they had developed a helpful relationship with the therapist.

Wanting a Role

In contrast to the three participants already discussed, Leana, the Johnsons and Shelly did not describe the relationship and their role with their child's therapist as satisfactory. All three discussed feeling distant from the therapist and not involved in the therapeutic process. Although Leana saw changes in her child, which the Johnsons and Shelly did not, she did not feel part of the process or feel that the therapist understood her perspective as a parent despite being involved in some of the sessions. She was invited in at the beginning of sessions periodically and asked to provide information to the therapist about how she viewed progress at home. While this involvement had contributed to a sense of satisfaction and the development of a relationship for the other participants Leana continued to feel misunderstood. Her perception was that she and the therapist viewed the situation differently. As Leana described her experience, "Oh, it was sort of you know, watching and waiting. But it didn't really happen, I didn't feel drawn in." Despite being given opportunity for involvement in the process Leana did not develop a sense of trust or a working relationship with the therapist as other participants with similar involvement had. Leana's relationship with the therapist continued to be affected by her feelings of being misunderstood.

The Johnsons had a similar experience feeling that the relationship with their son's therapist was distant. There was guilt for them around this feeling as they regarded her as a nice person. The therapist had met with Steve's school teacher and principal in an effort to help, but this did not contribute to the relationship with the parents developing further. They continued to feel that there was no change and they had no other involvement after the school meeting. Therapy was a process that was new to them and they did not feel they could confront the therapist with their concerns:

> Very distant, very distant. She's a nice lady. I like her, but she, well she did meet with the school which was very important...She was in the session with us (the school personnel) and it sort of felt good, because it sort of felt we had someone who was an ally, supporting us.

While initially the Johnsons felt supported, the relationship with the therapist eventually regressed to them feeling distant. They observed little change in Steve and wondered if maybe the therapist's approach was not working. Despite the lack of perceived progress the Johnsons continued to bring Steve to therapy, never questioning the therapist directly or feeling comfortable to raise issues with her. Even when they disagreed with the therapist or wondered if maybe they misunderstood the process they kept their concerns to themselves and did not discuss them with the therapist. The Johnsons were not invited to meet with the therapist or to have involvement in Steve's therapy and so felt they never had the opportunity to raise issues with the therapist.

> Part of it was lack of opportunity, and lack of knowledge of what she was doing. To say to her oh gee I don't think you know what you are doing, when I don't know what you are doing I can't make that judgment.

Steve's therapist had described the therapy as play therapy. While the Johnsons understood that it made sense for a child to communicate on their own level, they could not understand how this would help him and them to improve psychologically. Lacking understanding and perceiving the therapist as an expert led them to acquiesce to the therapist's judgment and process without confronting the therapist. They doubted their knowledge and ability to ask questions as parents, feeling they had no right to question the therapist who was supposed to know what she was doing. In many ways the lack of involvement experienced by the Johnsons maintained the sense that therapy is an ambiguous process which they were not to question or attempt to understand.

Like Leana and the Johnsons, Shelly was dissatisfied with the relationship she had with her daughter's therapist. Throughout the therapeutic process Shelly was not involved in any individual sessions and felt she was not given feedback nor asked for input as the parent. After the third session the therapist informed Shelly that Kayla did not want to talk about things and that there was no point continuing therapy. Shelly described many emotions with this experience:

> I was shocked when she (the counsellor) ended the sessions. I was shocked. She's been traumatized but there is nothing we can do for you so go home and good luck. There was no help...The counsellor talked to me afterward and she basically said that she has been traumatized and she is afraid to sleep in her own bed at night but that she doesn't want to share it right now so basically you guys go home and just continue on with your life...After three sessions she said go home and continue living in that home and keep an eye on her. We had no tools to help, we had nothing. I felt guilty myself that she had to go through that and without getting any help.

As her statement so aptly indicates, Shelly was confused and shocked that the therapist had not tried harder to understand Kayla and felt desperate as she did not know what to do next or how to help her daughter. From her view the therapist did not provide her with any guidance on how to deal with the situation. Despite Kayla's not talking in therapy, Shelly thought that she would have at least been given guidance or be provided with follow-up resources. Instead Shelly felt left on the outside and was not involved in the process: "Nothing was ever relayed back to me either. If she had, if my daughter had talked out in session or brought up 'My mom does this or upsets me,' I will never know that."

Shelly wished that she could have had more say or been asked for her input. She felt she could have given meaning to things that were going on that the therapist would not have been able to know about. As Kayla's parent Shelly felt she had some expertise to offer to the therapist to assist with understanding Kayla and the situation better. Hence Shelly wished for more interaction between her and the therapist.

> To me she drew some very disturbing pictures, she wrote some very disturbing letters. And the counsellor didn't interact with me on those pictures and my daughter sat there writing on pieces of paper 'Mom I need you, Dad I need you, Everybody I need you.' The counsellor saw it, I was just devastated. The counsellor saw it and said well you know I think we are done here. We left with absolutely no tools or anything.

Shelly perceived her daughter as asking for help, which was not acknowledged by the therapist, leaving Shelly feeling devastated, helpless, and misunderstood. Similar to when Leana had felt the therapist did not see her perspective, Shelly was disappointed and unsatisfied and described the relationship with Kayla's therapist in the same words used by the Johnsons: "distant." Like them she began to question whether it was her attitude that led to her disappointment. She felt the therapist viewed her as a mother looking for someone to say her daughter was sexually abused so she could get revenge and Shelly resented being perceived in this manner.

> Distant, because it (relationship) wasn't uncomfortable but it wasn't what we came here for. Maybe it was my attitude that if there is something wrong with the child then they can fix it and that psychologist couldn't...I just felt that the counsellor thought that I wanted to know what happened so I could go and get revenge. That's not what I was looking for, I just wanted to help my daughter.

Parents not invited by the therapist to have a role or be involved remained anxious and uncertain throughout the process. Even if provided the opportunity for involvement, if the parent felt misunderstood, then an active parental role did not develop. Parents lacking involvement did not feel comfortable to address these concerns with the therapist and felt the parent-therapist relationship was distant. Instead the process was perceived as ambiguous and parents were unsure if their role could even be different. The common element raised was parents wanting a role and involvement in their child's therapeutic process. Parents wanted reciprocal communication regarding their child's problems and progress. They wanted to be given and to provide feedback to the therapist.

Fearing Blame

All participants raised issues of blame and guilt. Some questioned whether their child would say something that might highlight the problems as the parents' fault. Perhaps the therapist would blame them outright for their child's problems. Participants evaluated the quality of the parental role they played in their child's life. Each discussed the importance of the therapist validating them as parents: to be told that they were a good parent was important.

Many emotions were identified when participants discussed their concerns that their child's problems may be their fault. Leana explained the guilt she was feeling that resulted from having Jane attend therapy as she feared she may not have done for her daughter what she could have or should have. She considered the impact of being a working mother and not having spent the time with her children that was needed. She wondered if she neglected their needs which resulted in Jane's need for therapy. While Leana initially blamed herself, this feeling dissipated as therapy progressed. Discussions with Jane and with the therapist of the problems allowed her to learn she was not to blame. Leana described the guilt she felt as follows:

> For me as parent you feel a lot of guilt especially when you are the mother and you work and when you get home you are tired and maybe you are not (sigh) you can't give that focus that you wish you could to your kids.

Like Leana, June also felt guilty. She evaluated how she viewed other parents, reasoning that when she saw something go wrong with a child she often wondered what the parents were doing wrong. Now she saw herself being the parent who may be blamed. She feared that maybe the therapist would see it that way also.

> I was the primary caregiver so when something happens to your child you think what is going on with those parents... I think we were mainly concerned that what we were doing at home was resulting in some sort of behaviour. But he told us

> this was not the case... I guess it was good to have someone say it. I didn't want to think that we were doing things that were, well, what we were doing was only part of the problem.

June found it helpful and a relief to hear from the therapist that she and her husband were not causing her daughter's difficult behaviour. Melanie also had the experience of being assured that she was not doing everything wrong for her child. Melanie, like the other participants, had placed blame with herself:

> I know it was a learning experience and helpful for my daughter and me. I at least knew I wasn't totally screwing up. Making her a dysfunctional person or something. It was supportive for me. I appreciated that. Not just for the positive things but also to be able to see I could do or change this behaviour to help her.

Being validated by the therapist helped Melanie to be able to see not only the good things she did as a parent, but to be able to accept those things she could change to help Kelly. Without validation and acknowledgment from the therapist Melanie indicated that she would not have been able to make changes within herself as easily. She felt that making changes in herself and her parenting and examining her contribution to her child's situation involved her in the therapy process. She was able to see how things were progressing and the role she played. Both Melanie and June found it helpful to receive validation from the therapist giving them the sense that the therapist supported them as parents.

Self-blaming thoughts played on Kerry's mind for several weeks once Jeremy began therapy. Each session she wondered what Jeremy may be saying that may implicate her as the cause and feared that Jeremy would hate her. She spent much time in the early weeks of treatment ruminating about her fears and blaming herself. As she describes:

> Oh my God! Is he saying all of these horrible things and hate will take over my child? So it took me a couple of sessions to relax. But I was aware that the sessions were for him and it was not for me. I was not a part of that. I mean he (counsellor) filled me in on some things after our first meeting with him and since it is usually me who brings him, we had gone through I don't know how many sessions, it was just near Christmas, and my son and I had a session with the counsellor where he gave us some positive feedback that we are really doing well as parents, you know the good stuff, the stuff that parents want to hear... Actually I had thought that maybe I wasn't doing all of the things I should have been. I thought that maybe, well, well I was a failure as a parent. You know I couldn't make the marriage work. I felt responsible for his behaviour at school. I mean me and my kids are home all week and gone most of the weekend but I am the greatest influence, I am the greatest influencing parent in their lives. I am the constant parent, I always have been from the day they were born. I know I thought I was somehow responsible that I did something wrong as a parent.

Kerry had thought about her role in Jeremy's problems intensely. Having to bring him to therapy and worrying that she may be in part to blame for his problems raised many issues and she began reviewing other areas of her life. She considered herself responsible for her failed marriage and subsequent divorce and felt this contributed to

Jeremy's difficulties. She felt responsible for his misbehaving at school. Kerry's thoughts in the early stages of treatment were focused on self blame and her perception of herself as a failure as a parent.

The turning point for Kerry was a joint meeting with her, Jeremy, and the therapist that occurred several weeks after therapy began. Kerry was quite surprised and pleased to hear the therapist's positive feedback. The therapist reinforced good choices she was making as a parent. Her anxiety and fears lessened. She felt validated as a parent and allowed herself to continue with the therapeutic process with less guilt and an increasing sense of comfort.

Parents tended to begin therapy with the fear that the child's difficulties were their own fault. Parents feared being blamed. This fear of being blamed was driven by their own thoughts of guilt and failure. Parents brought to mind possibilities to support their feelings of guilt and the possibility of blame. These feelings were resolved when the child's therapist met with the parent(s) and validated their parenting. Parents experienced a sense of relief and support. The experience of being validated helped parents to change their focus to how they may help their child by making changes themselves.

Feeling Blame

Shelly and the Johnsons had a different experience compared to the other participants and did not receive validation as parents from the therapist. While the Johnsons did not discuss this topic in as specific detail as the others, they did reiterate that they felt ill equipped to help Steve and doubted their abilities to understand him or change things. While the Johnsons longed for someone to tell them they were acceptable parents, their insecurities and perceptions of being inadequate parents kept them from believing they deserved such validation. Instead they maintained the perception that they were failing and lacking skill and continued through the therapeutic process being disappointed that Steve's therapist did not attempt to fill the gap by providing them with parent training.

Shelly too was disappointed at not being validated and supported as a parent. Like the other participants, self blame was a theme for Shelly. She wondered if she did not spend enough time with Kayla or whether Kayla felt unloved. Much of Shelly's self blame came from her sense of guilt that Kayla may have been sexually abused and that as a parent she had her own feelings that accompanied such circumstances. The therapist did not validate her experience and feelings:

> She didn't support me as a parent, whether I had feelings about it, maybe guilt or whatever that was never brought up...I guess a lot of the perception was that this happens and get over it. I had to go for my own counselling to deal with that and I did not feel I was looked at as a mother whose child was traumatized but that I was just an angry mother. I was just another casualty and needed to get on with life.

This was not helpful to Shelly. Her views and feelings were not validated or supported. Despite seeking her own therapy she continued to feel misunderstood. Not having her views and feelings about Kayla's difficulties validated or even acknowledged was unhelpful for Shelly. Shelly felt that even though the therapist indicated that Kayla was not ready for therapy Shelly's pain attached to her daughter's difficulty could have been acknowledged. As the parent of the child in therapy she had her own feelings and emotions that were attached to the process and situation and these were left undealt with, leaving her feeling unsupported. Instead of resolving these feelings as the other parents had, Shelly continued to feel guilty and at fault. When discussing her experiences there was also a quality of bitterness apparent in her tone.

Being In the Waiting Room

When a child is in therapy the parents often spend much time in the waiting area. They sit and wait. Five participants raised this as a significant experience. Parents identified their thoughts and feelings while waiting for their child to return. These feelings included anxiety and worry, feeling left out and uninvolved, and feeling comfortable and relaxed. This seemed to be a particularly salient time for parents to engage in their internal dialogues regarding their child's therapy. The following is a discussion of this period of time for the parents.

For June, time in the waiting room was for her, as she did not spend time contemplating what was happening in the session. Instead, from the onset of the sessions she felt that they were Sarah's own private time. This is in contrast to the experience of the other participants. While they may have eventually been able to use the waiting room period as relaxing time, none of the other participants began the experience in the same manner as June. Melanie's description of her experience highlights this:

> Initially I was distracted by other things, then over time I could block things out. I used to think about what she was doing here and about the things we discussed on the way here...I found having that good rapport with the counsellor really made

> me feel secure and I had no trouble sitting out there in the waiting room. They would call me in if there was a problem, and they both knew that...And so I would sit out there and have my crossword puzzles to do. Realizing this is going to be my place more and more, sitting back. But being here and in a heart beat I would be there. But she never called for me. She was starting to handle things on her own, and that was good.

For Melanie, becoming comfortable in the waiting room was a process that was dependent on her sense of reassurance of having a relationship with Kelly's therapist and having developed a sense of trust in the therapist and therapeutic process. Trusting the therapist helped her feel at ease that she would be contacted if were needed in the session. Initially Melanie spent her time wondering about what was going on for her daughter and if she was needed, but over time she began to see her role change. She saw Kelly mature and make personal improvements, which allowed Melanie to step back from an active role and develop a sense of comfort with the waiting room. Eventually her crossword puzzles became the primary focus of her attention.

In a similar vein, Kerry progressed through a process of initial worry and discomfort to one of reassurance. In the beginning Kerry paced the hallway and smoked nervously. It was during this time that she reviewed her parenting and contemplated the issues of self blame that were addressed previously. This concern began to change when Kerry was invited into several sessions with the therapist and Jeremy. After receiving reassurance and validation as a parent she progressed to being more comfortable with the therapeutic process and her time in the waiting room:

> I felt more relaxed. That now gave me my hour, my time. I would go down to the cafeteria, have coffee, go sit, read an article, then finish the article and bring the magazine back. Over a period this kind of got to be my time too.

The combination of having developed a relationship with the therapist, being validated and feeling reassured were important to both Kerry and Melanie to have a positive experience in the waiting room. The change in their relationship with the therapist was reflected in their activity and internal dialogue while in the waiting room. Both parents shifted from anxiety and concern to feeling comfortable and reassured, therefore began to enjoy the wait as a leisure time.

While Mr. Johnson also developed his waiting room experience into time to read, his process was much different. He never felt the reassurance or had the rapport with the therapist that the others described. Mr. Johnson was distracted by the experience of other parents around him who were also bringing their children for therapy. It was primarily Mr. Johnson who brought Steve for therapy, and the following is a description of his experience:

> Well what I normally did in the first couple of weeks was I brought a book and I just sort of, it became an hour of reading time. So I was kind of looking at it as a quiet time. In some cases it was just absurd. I'd think OK, here's some parent with a kid with some problems, I'm not alone, we're not alone, other people have this. I knew that but this was reinforcement. So sitting in the waiting room was basically a chunk of time where I was almost shut down. Someone else is taking care of him.

Initially sitting in the waiting room Mr. Johnson thought he would be able to relax. However, observing other parents enabled him to see he was not the only parent having problems with his child, which provided him with another perspective. Actually seeing the other parents reinforced and validated for him that other parents struggle also. While the waiting room allowed him temporary relief from the stress of parenting his son, as time progressed and he witnessed other parents' involvement with their children his perspective began to change and he wished for more involvement:

> It would have been better to have been more involved with what was going on...To be more involved like the other parents. Having sat in the lobby or seen other mothers bringing the kids, I've seen fathers, two parents bringing kids, uh, and just in observation. Most of the time I sat there by myself, other parents disappeared behind a door and I just sat there. It just seemed there should be more interaction between the counsellor and the parents.

The role Mr. Johnson had in his son, Steve's, therapy was different from what he witnessed other parents experiencing. While initially he was comfortable and relaxed in the waiting room, as he noted the level of involvement others had, his perspective changed. He felt unsatisfied with the lack of tools, guidance, and feedback provided. Having observed other parents do more than transport the child contributed to an increased dissatisfaction. Not being involved in Steve's therapy, he did not develop the sense of trust and comfort with the therapeutic process that the other participants described. Observing other parents in the waiting area and how his own experience seemed to be different validated for Mr. Johnson that his therapeutic involvement should be different.

Like Mr. Johnson Shelly did not appreciate the waiting room experience. Already dissatisfied with the process, the waiting room increased her frustration:

> I feel that I could have been offered a lot more if I had been talked to about how she has or has not progressed or things she said to the counsellor or to me. I know that I have to stay in the waiting room because we are respecting my child's rights to confidentially, but I have to take her home and live with her.

Being left in the waiting room signified the lack of involvement and feedback that Shelly had. She was aware of her child's right to privacy, but struggled to balance that with her need as the parent for information and involvement. Shelly felt that there was no opportunity to balance what she was needing with what her daughter needed to maintain a therapeutic relationship with the therapist. The structure of the therapy did not make sense to Shelly nor meet her needs as a parent for communication and feedback from Kayla's therapist.

Summary

It is clear from the participants' experiences that even though the child was the one receiving therapy, the parents had their own internal processes about the situation and attributions as to the cause. Parents' thoughts and emotional experiences illustrated a process of internal dialogues related to self-blame and guilt. These dialogues conveyed the emotions of fear, guilt, and anxiety within the parent. All participants wondered if it would be discovered that they had made a grave mistake or mistakes as a parent. Would someone blame them? Feeling supported and validated by the therapist was a powerful experience that helped parents feel relieved, supported, and involved. The experience of validation played a role in the development of positive parent-therapist relationships. Not receiving such validation and support from the child's therapist led to distressing feelings being maintained rather than resolved. Parents' emotions were undealt with, which sustained their perception that they were at fault as no one had told them otherwise. Lacking validation seemed to interfere with the development of a helpful relationship with the therapist. The therapist was not perceived as helpful, supportive, or understanding of the parent.

The waiting room was a place where participants experienced a variety of emotions and experiences. Those who developed a satisfying and trusting relationship with the therapist had a different experience from those who did not. While most initially felt nervous, apprehensive, and fearful on the first few occasions in the waiting room, their feelings changed with the development of the relationship with the therapist. As a sense of trust evolved, these participants became comfortable and even began to view the child's session as personal time. Feeling validated as a parent and reassured by the therapist was important to this progression.

In contrast, those who had been unsatisfied with the therapy and were not provided with any feedback or involvement in the process had a more difficult experience in the waiting room. These participants felt isolated and frustrated. As other parents were observed being involved, the desire to be a part of the therapy increased. Parents whose experience consisted of primarily being left in the waiting room did not develop a positive and effective relationship with the therapist that led to a sense of comfort and trust with the therapeutic process.

Theme 4: Impacting

All of the participants discussed how their decision to seek therapy services impacted themselves and others. The therapeutic process was described by several participants as impacting others in the family besides the child who received therapy. Kerry noted less sibling rivalry and fighting. The relationship between brother and sister seemed to change as a result of her son making changes. Similarly, Leana saw an impact on the rest of the family with her observation of a difference in everyday interactions and stress. The family was not as concerned with upsetting her daughter and the aftermath of that upset. Overall they were less stressed as a family:

> It (counselling) impacted the rest of the family because it was stressful for everybody. It just made the household nicer to be in...It was really a gradual thing but it was less stressful at home. Everyone wasn't so uptight and worried that oh, you know something I say or do is going to set Jane off. So, just a lot calmer.

Parents focused more on the impact on themselves. Four participants discussed how the therapy of their child impacted them as the parent in terms of changes made or felt. The predominant impact on Melanie and Kerry was relief as they felt that someone was able to help their children make positive changes. They indicated that they were reassured that things were going to be better. Shelly and June each sought their own therapy to look at themselves and their own situations. Through her own therapy Shelly felt able to explore her own thoughts and work through the issues that had been raised for her by her daughter's therapy:

> I did go and see another counsellor myself...I started to get a more, after my therapy I became more perceptive of what was going on and at gathering my own thoughts.

June began to evaluate herself so started therapy for her own personal issues. Initially she wondered how she had caused the problems with her daughter. This led to evaluating how they interacted and what implications her parenting style had for her as a person. She questioned her own happiness and her marriage:

> It was my daughter. I thought maybe I had made her go (run away). So I thought to think how did I treat her, what am I really like, am I happy, why was I not happy. It was my daughter in counselling that made me do that, to take a look...So I started looking at everything, at the girls, how I was perceiving myself and how my husband and I were interacting. My husband said I was becoming the person that he married. He said, "You are becoming the person I knew in the first place."

Being in therapy was a profound experience for June. She was able to work through her own issues independent of her daughter's therapy and to accept how she may be impacting the family. While her own therapy may have initially been a reaction to her perception that Sarah's problems were June's fault, she examined more complex issues such as her own happiness and her marriage:

> I was going through a bad time. When you start facing your problems you start facing your marriage, and you start facing how you interact with her husband and

> with your children. So we sort of came full circle. A big change in our lives, a big positive change.

While the outcome for June was positive, confronting herself and engaging in therapy was a difficult experience. She had to be truthful to herself and examine her relationship with herself and significant others in her life. Sarah's therapy impacted June's life as a person, wife and mother and prompted her to examine each of these roles.

Kerry, Leana, and Melanie had to cope with letting go of aspects of their involvement with their child. A normal part of child development is moving away from the parent and developing independence. Having their children in therapy launched these parents into the process of letting go. Leana realized this very early in the therapeutic process. She found herself picking up and dropping off Jane for sessions with little interaction. She recognized that Jane was going through some changes and would likely pull away from her somewhat. She was reluctant to let this happen as she did not feel Jane was ready for independence. Similarly for Kerry, Jeremy was not discussing sessions with her. Helplessness and anxiety were her feelings following the realization that he was excluding her for the first time ever. Kerry explains:

> I was anxious and worried. I mean was he going to cry? Was he going to need me?...the hardest part for me was placing my child's emotional well being in the hands of someone else. (I felt) excluded, helpless. Kind of like when your child goes to school for the first time, it's not control, it's that you're no longer a part of their life on that level. You don't know everything that happens anymore...He did not want me to be a part of that. I don't know if it was growing up but it was like

> oh, besides school this is the first thing he's ever excluded me from.

As described by her statement this was a new and difficult role for Kerry to accept. Her son placed her on the outside. Emotions flooded Kerry as she considered being in this position for the first time. While she acknowledged that this may be a part of his growing up and getting older, as his mother Kerry continued to wonder if he would need her. This was the first time she was not the one meeting his emotional needs, and she felt anxious about it and wondered where she fit in.

Like Kerry, Melanie struggled but was able to view letting go as a positive and natural part of development. It was an opportunity to take advantage of Kelly growing up and depending on her less. While it was emotional for her and she had to grieve her previous role as the one Kelly depended on she viewed it as a learning experience for them both.

> Well, you feel a little grief. But because they are growing up, I thought this is a good thing and I can't be there for every hardship and so she's getting some boosts in her own abilities and some help and some comfort...It was partly as good for me as it was for her because I had to do some letting go, because I had her right here all the time. I find this is sort of, you have to start to let go, let them become adults. So I thought here is a little letting go lesson.

Melanie was able to step back and give Kelly some independence as she knew she could not always be there for Kelly and was reassured of knowing someone was there for Kelly. Melanie struggled throughout the therapeutic process with learning to adapt to the new role in her relationship with her daughter. Melanie viewed therapy as providing the advantage of a safe context for Kelly to begin relying on her mother less.

Summary

When a child was taken for therapy, other important people in the child's life were impacted. As parents perceived their children improve, the families' stress levels decreased and relationships with the child improved. Parents themselves were particularly impacted with emotions ranging from relief to anxiety and fear. Having a child in therapy also triggered some parents to evaluate themselves, to examine their own lives and feelings and seek their own therapy. Participants discussed how they felt that the therapeutic process triggered the child to be less dependent on the parent and rely more on him or herself as a resource. For some parents therapy initiated a letting go process in which parents had to accept their child's growing emotional independence and adjust to the new role that the parent was being placed in. Some parents seemed more accepting of the child's movement towards independence and viewed therapy as an opportunity to begin this natural process in a safe environment. Parents who identified discomfort with the letting go process had not developed a sense of trust with the therapist or had children who were elementary school age and thus the child's growing independence was unexpected.

Theme 5: Evaluating Outcomes

At the end of their child's therapy process, the parents looked back to evaluate what they received from it. The final phase of the therapeutic process involved the ending of treatment over several sessions or ending abruptly. Following the last session each looked back to review the process and the outcomes. Five of the participants discussed these outcomes for themselves and their children.

Experiencing Therapy as Unhelpful

Shelly clearly felt that she did not receive what she needed and viewed therapy for her daughter as unhelpful. She was disappointed and experienced strong negative feelings about the experience stating that she would not engage in the therapeutic process with her daughter again:

> I feel that I have lost. If she brought this up again and wanted to deal with this I would not take her to another therapist because I would not want to do that to her again, to drag her through that. It is not worth it.

Shelly's daughter's therapy had been ended abruptly by the therapist at the end of the third session. Shelly had not been expecting therapy to end as from her view nothing had been accomplished and no questions regarding her daughter had been answered. Shelly thought they were at the beginning stages of therapy while the therapist felt that further appointments would not be helpful. The disappointment she experienced left her feeling defeated. The poor relationship Shelly had developed with the therapist was reflected in her sense of defeat. She viewed therapy as something she put her daughter through, causing her distress without the benefit of improvement. The distress both mother and child experienced was not something they were willing to engage in again.

For the Johnsons, there was a mix of emotions. They were disappointed that they did not get from therapy what they had expected. From their perspective they did not accomplish anything except temporary relief from the school. They finished therapy with the same difficulties and feelings they had when they started. Communication was still a problem with their son and his behaviour had not improved. No change had occurred and they continued to struggle with how to help things be different:

> As a parent I never got anything out of it except relief from the school system who thought we were doing something. I don't know even more so today how to communicate with him or how to explain things to him that would make it better for him...Having gone through it all there is no light at the end of the tunnel. It's like oh, God is he going to be like this for the rest of our lives. I know that's not true he's nine and five years from now he is going to be a different kid. But getting through it day by day. I hate myself right now. I come home, I get to the front of the house, and I feel the anger. What did he do this time?

Clearly there was disappointment when their son did not improve. Anger and frustration was evident as they continued to deal with the stress of daily struggles with Steve. While they saw that things could still change, they were unable to see how. Living with Steve day to day was difficult and therapy did not provide relief for their situation. Tools and guidance of coping and managing their child were not acquired and they felt they gained little in their continuing struggle.

Interestingly, although there was little benefit to therapy, they did not regret or resent having chosen this route. They indicated they would likely try again with another therapist. Both took their parental responsibilities seriously and were willing to do whatever was needed to help their son. In many ways there was a sense of desperation. They want to help him, but continued to not know how. While the Johnsons were clear that they had difficulty understanding the therapist's approach, they had difficulty expressing any therapist qualities that may have contributed to their perception of a negative experience. They often qualified their statements regarding obstacles in therapy with the comment that the therapist was a nice person. Other participants were noted to struggle in a similar way; even those who described a negative aspect of an overall positive experience tended to comment that they did not mean anything personal towards the therapist. As well, participants seemed to be concerned that since the therapist was in training that negative comments may affect the therapist in some way.

> I don't resent having come here. I'd get up every morning so I had to get up early one more morning. Whatever, I'd have gotten up at 3 AM if it was going to help. But to have done that for three or four months and to have seen no change for the better or worse, I don't know. There just didn't seem to be any value in what we did. And the whole point is we have to help this kid, we can't abandon him.

Experiencing Therapy as Helpful

While the Johnsons and Shelly felt frustrated and disappointed at the end of the therapy, the other participants described more positive views. Melanie felt it was helpful and she was able to see her daughter practice the strategies she learned. Kerry stated that she observed continued changes once therapy was discontinued: "I think once my son realized that counselling was finished he knew it was all up to him. I think that is when the big changes happened." She understood this as an indication that Jeremy now was able to solve problems for himself. She noted he was aware of how to deal successfully with difficulties. June noticed similar changes with Sarah, who was now able to handle the bullying situations at school effectively and without upset. She also was now better able to come to her parents if there was something she could not handle. June felt more at ease herself. As June described it in simple terms that meant so much to her, "Sarah was becoming Sarah."

Summary

Varying perspectives of the therapeutic experience emerged from the parents' descriptions. Parents observed positive qualities of their child emerge amongst the difficulties and frustrations that characterized the beginning of the process. Parents who were unsatisfied described distant relationships with the therapist and felt their needs were not being met. Unfortunately, one decided that she would never do this again, while the other decided it was better than nothing. Frustration, disappointment and stagnation remained evident for parents with unsatisfactory experiences regardless of the length of therapy. These parents described the parent-therapist relationship as unhelpful.

Throughout the interviews participants discussed the importance of the decision to take their child for therapy. Each had accessed a variety of resources prior to beginning this process. They had talked to school personnel, guidance counsellors, family support workers, as well as family and friends. Each felt that they had exhausted these resources. Initiating the therapy process resulted from various triggers including decisions as a family, suggestion of the school, and just feeling unable to cope as a parent. Part of the difficulty that was involved in the decision was the frightening question: what could be wrong with my child? Many emotions from fear and anxiety, frustration and even embarrassment and failure were experienced.

Preconceived ideas of what might happen in therapy were held by all participants, and all engaged their children in therapy with expectations. While parents expected the child to gain from the therapy, parents tended to focus their expectations and disappointments on what they themselves may gain from the therapeutic process. While the therapy did not meet all of these expectations, the parent-therapist relationship played an important role in the overall experience.

An important result of developing a relationship with the child's therapist was feeling involved in the process characterized by didactic communication, feedback and guidance that contributed to a positive experience and a feeling of trust in the therapist. Receiving validation from the therapist was an important component to the development of this relationship. Parents tended to be involved in a process of internal dialogues throughout the therapy experience that initially focused on self-blame and guilt. Validation and feedback from the child's therapist helped relieve these fears and further contributed to a helpful relationship between the therapist and the parent.

Those who described the relationship and overall experience in positive terms were able to observe positive changes in their child and were satisfied with the process. Parents who felt the relationship did not develop with the therapist viewed the process as unsatisfactory and continued to remain frustrated. Parents who failed to develop a parent-therapist relationship were less likely to have experienced validation as a parent or to have been provided guidance on how to help their child. These parents felt they were excluded and lacked any kind of involvement. The internal dialogues of parents with an unhelpful relationship with the therapist did not evolve beyond self-blame and insecurity;

hence a sense of comfort and trust with the therapist or the therapeutic process did not develop.

In sum, if the child did not progress then neither did the parent's emotional state, internal dialogue nor the parent-therapist relationship. If the parent-therapist relationship was not perceived as helpful, parents were less likely to describe their child as having changed. The relationships of those involved, parent(s), child, and therapist, were reciprocal and multi-directional.

CHAPTER SIX

Discussion

The findings of the present study highlight that parents of children receiving therapy also experience a process. The process of parents is necessary to understanding child psychotherapy and hence to developing effective interventions for children. The fact that parents are the decision makers in the child's life and take the important step to bring the child for therapy highlights the importance of parental process. Parental process in child psychotherapy, however, is an area that has not received attention in the literature.

The question that was investigated in this study focused on aspects of parents' experience of the relationship with their child's therapist, and the expectations that parents have for the relationship and their role in their child's therapy. The results suggest that it was difficult to discuss this experience in isolation without considering how the participants' emotions and thought processes were intertwined with the therapy experience, contributing to an overall integrated experience.

Research Findings

An effort was made to understand this experience through discussion of the thought processes and emotions of parents. Through an analysis of the data, five themes were identified in the results that were common to the experiences of the participants. From the prospective of the larger picture of the total parental experience, it appears that the results reported have common threads that link the experience from beginning to end. The discussion of these findings is intended to pull together the themes from the analysis which seemed to be characterized by a sense of parental process and internal dialogues. Each of these findings is discussed to demonstrate the similarities, differences and gaps within the present body of knowledge of child psychotherapy.

A brief outline of the major findings of the present study as they contribute to the current body of knowledge of child psychotherapy is presented below; then a comparison of findings in the literature follows. The major findings are:

1. Parents described expectations about what they expected to gain from having their child in therapy. These parental expectations represented the internal structure that parents put together as they prepared themselves for their child's therapy. It is through these preconceived ideas that interactions and events that occur throughout the therapy process were compared and filtered.
2. Parents experienced their own process throughout their child's therapy which was characterized by an internal dialogue as parents encountered a decision-making process that began even before the referral for the child to receive therapy was made. Parental process was influenced by interactions with the child's therapist.
3. Parents expressed a need for a role in their child's therapy beyond being the receiver and provider of information. The desire for a parental role was driven by a need to contribute to and help facilitate the child's therapy.
4. The presence of an alliance or working relationship between the parent and therapist was important to parents. Parent-therapist relationships perceived as

helpful were more likely than those perceived as unhelpful to meet the parents' need for an alliance with their child's therapist. Parents who described helpful relationships were more likely to also describe aspects of change for their child and themselves than those who described unhelpful relationships.

5. Participants' experience of the relationship with their child's therapist was triadic in nature and represented child therapy as involving multiple systems beyond child and therapist.

Expectations of Parents

Throughout their child's therapeutic process, parents engaged in their own internal dialogue and process, of which an important component was parental expectations. Expectations can be defined as the anticipations that a client holds about the behaviour of those participating in the therapy process (Bonner & Everett, 1986) and created the context within which evaluations of success were made. Parental expectations appeared to represent the internal structure that had been developed to prepare for the experience of bringing a child for therapy. They were the framework of preconceived ideas that events and interactions that occurred throughout the therapy process were compared to and filtered through. This is consistent with Nock et al.'s (2001) conclusion that expectations represent what parents bring to treatment and what they connect with the actual procedures and processes that they are presented with.

Unmet Expectations

All of the parents in the present study had expectations that were both met and unmet, each of which played a role in their decision making and experience of having the child in therapy. The expectations that parents have for a child's therapy are important to understanding decisions that parents make during their child's therapy such as discontinuing or maintaining treatment. The parents in this study all had completed therapy which may have made them different from those who did not and were not interviewed. Many parents who seek help for their child fail to follow through for various reasons (Morrissey-Kane & Prinz, 1999). Nock et al. (2001) compared the expectations of parents who terminated therapy early to those who did not. Prior to beginning treatment, parents who believed that treatment would be effective and who had expectations about the structure of therapy that were congruent with the actual structure were less likely to terminate prematurely.

However, whether describing their overall experience as positive or negative, parents in the present study had unmet expectations, suggesting that merely having unmet expectations is not necessarily enough to warrant the decision to discontinue therapy for the child. Although each of the children of the parents completed therapy, the parents differed in their overall assessment of the experience. First, parents with negative experiences tended to have high expectations for change to happen quickly and viewed the therapist as an expert. These parents also had more difficulty developing a therapeutic alliance with the child's therapist. This finding is consistent with Elliott (1995), who found that unmet expectations of parents negatively impact treatment, with those who drop out perceiving the therapist as less caring and involved.

Further, deciding not to discontinue therapy in light of unmet expectations may be related to the parents' perception that they would be unable to resolve the situation on their own. Parents dissatisfied with treatment felt they did not receive guidance on how to solve their child's problem, felt inadequate as parents and were less involved in the therapy. Parents tended to view the therapist as an expert who could fix the child and would tell the parents what to do. Morrisey-Kane and Prinz (1999) surmise that some parents may not have confidence in their own abilities and believe therapists can "fix" their children. Parents with such an external locus of control tend to be more dissatisfied and have poorer treatment outcomes. Tinsley et al. (1993) found that therapists view clients as tending to underestimate client contributions to therapy and overestimating therapist expertise. Clients expecting an expert are not anticipating an evenly balanced relationship and thus are less likely to collaborate with the therapist (Al-Darmaki & Kivlighan, 1993), which may contribute to poorer outcomes and less satisfaction.

While parent perception of unmet expectations in the current study at times appeared to have a negative impact on the parental process, none of the parents chose to discontinue therapy regardless of their perception of the therapist, unmet expectations or improvement of the child. As noted by Kazdin (1998), while improvement is strongly related to treatment completion, some of those who drop out improve and some completers do not.

Changing Expectations

Interestingly, when parents in this study had unmet expectations there was a tendency to re-evaluate these preconceived ideas in light of the unfolding experience.

Expectations then were a phenomenon that shifted and changed. Parents compared these preconceived ideas with the actual event that occurred and even changed their expectations to fit the reality of therapy. Once expectations were re-evaluated they too were interwoven into the parental process that occurred when the child was in therapy. Parents and therapists may have different expectations that influence improvement and completion (Kazdin, 1998) and these expectations seem to converge as therapy progresses.

Some parents did experience positive events that they had not expected. This may have reinforced their decision to continue their child in therapy. Other parents continued to send their child to therapy regularly even while feeling frustrated and disappointed. These parents had very high expectations and may have continued to send their child in hope that these expectations would be met in future sessions. Parental distress may be high enough that out of desperation the parents seek help even if expectations for change are low (Morrisey-Kane & Prinz, 1999). Nock et al. (2001) found that parents who had both very high and very low expectations came to the greatest number of therapy sessions and were least likely to terminate prematurely. While they concluded that no explanation for this finding is available within the literature at this point, it may be that those with low expectations receive more out of bringing their child to therapy than expected, with therapy exceeding their expectations.

As therapy progressed parents in this study tended to question their initial expectations and some expectations appeared to change. Having brought a child to therapy may have encouraged parents to continue their child's participation in therapy in light of unmet expectations as it provided them with correcting information. Many people stay in therapy who enter with unrealistic expectations (Arnkoff et al., 2002). Rey et al. (1999) found that parental satisfaction increased with two or three sessions attended, which they believe reflects a convergence of the understanding of the process compared to parents who attended only one session and tended to be most dissatisfied. There is also evidence in the literature that parental expectations can be changed when parents are provided with information. Providing parents with prefatory information regarding treatment is found to be effective in increasing children's and parents' knowledge of the treatment process, their receptivity to treatment, and their expectations for outcome (Bonner & Everett, 1986). A study comparing different venues of client preparation prior to initiation of treatment as a contributor to treatment completion and improved expectations found that a combination of a brochure and videotape increased accuracy of parents' expectations, with brochure alone having no effect. Parents with more accurate expectations had higher rates of treatment utilization (Shuman & Shapiro, 2002). It may be that parents in these studies had better response to the videotape as it presented the therapy structure.

In the present study expectations seemed to change as parents engaged in an internal dialogue and processed information from the therapeutic experience. Similar findings are found in adult studies. Satterfield et al. (1995) suggest that different stages of change may be related to client expectations. Tracey and Dundon (1988) found that expectations increased from the first to mid session and were related to positive outcome. They presumed the counsellor contributed to the change in expectations through the working alliance influencing client expectations to match those of the reality of therapy. Initial expectations are supported or refuted by the actual experience in therapy (Arnkoff et al., 2002). The more congruent expectations are with the actual experience of therapy the more likely there will be a positive view as incongruence strains the therapeutic relationship making termination more likely (Tracey & Dundon). Al-Darmaki and Kivlighan (1993) suggest that it is congruence of expectations, not whether one has high or low expectations for the relationship, that is important to the strength of the alliance. Currently there is little knowledge of how parental expectations change, and future research is needed (Arnkoff et al., 2002).

Parental expectations are an important contributor to the more extensive parental process and inner dialogue. In many ways, expectations provided the structure whereby all other experiences of having a child in therapy were processed and even restructured. Therapist understanding of parental expectations needs to expand beyond the current focus on its role in premature termination of treatment. Parental expectations need to also be understood as an important ingredient in the therapy process that is present from the beginning of the decision-making process and through which further decisions are filtered. These findings emphasize the need for parents to be seen as having their own expectations (Elliott, 1995) that impact the therapy process for the child. It is likely that understanding parental expectations addresses more than why parents terminate early, and unmet parental expectations likely are not the only contributor to premature termination.

Parent Process

Parents in the current study identified a process that went beyond that of the experience of the child in therapy. It included a decision-making process prior to the child beginning therapy, as well as during therapy and following termination. The decision-making process was characterized by several shifts. The process began prior to the initiation of treatment. Feeling desperate and depleted of resources contributed to the decision to refer a child for therapy. While parents considered their child's behaviour and what may be wrong, there were intense feelings associated with their inability to cope with the child. The parents' feelings about their child's behavior contributed more to the decision for a child to be referred than the child's behaviour itself. The referral was dependent on the parent, rather than directly on the child's distress. The presence of child problems did not seem sufficient to explain why parents refer to therapy (Morrisey-Kane & Prinz, 1999). Morrisey-Kane and Prinz state that parental perception of child behaviour and burden predicts referral more strongly than clinician- or teacher-rated severity. The presence of child psychological problems may not be sufficient by itself for the initiation of treatment, and therefore, it is important to not just understand the outcome of the therapeutic process but to consider the whole process.

Blame and Stigma

Once the child's therapy process began, parents continued to focus on their own emotions and thoughts in addition to attending to their child's. Parental process in the current study was characterized by an internal dialogue initially focused on fears and self doubt. Parents feared that they may be responsible for their child's problems and, already blaming themselves, feared being blamed by the therapist. Ferriter and Huband's (2003) qualitative study interviewed parents of adult children with schizophrenia and discovered that parents tended to blame themselves even when not directly blamed by others. Self-blame in parents occurred in the absence of being blamed by others even when parents were aware of a biological model of cause.

Some participants also expressed feeling stigmatized by having to refer their child for therapy. This perception of stigma in the current study seemed to emanate from parents' perception that needing to access therapy meant they were failures as parents. In this sense stigma appears related to self-blame and more related to parent perception than to actual experience. Michelson (2001) differentiates between perceived and social stigma. Perceived stigma is defined as the individual's personal feelings about the stressor, such as embarrassment, shame, or deviance, and the projection of these feelings onto others, which may not accurately reflect society's feelings about the stressor.

In the present study a critical shift in the process of self-blame occurred if these parental fears were addressed by the child's therapist. Emotions changed as validation from the child's therapist alleviated fear and self blame. The interaction with the therapist highlighted the impact that a child in therapy has on parents. The shift in the parents' process appeared influenced by parent-therapist interactions which led to changes in parental behaviour, thoughts, and emotional processes. The impact of a shift in internal perspective was evident in the experience of the waiting room. At the onset of therapy parents felt uncomfortable being in the waiting room and their thoughts were internally focused on fear and self blame. As parents became comfortable over the course of several weeks they began to view it as their own relaxation time and focused their thoughts on topics unrelated to the child or therapy. Parent's perception of a non-blaming attitude from the therapist seemed important (Friesen, 1992). Ferriter and Huband (2003) did not report a similar shift in parental self-blame although their participants reported not receiving information about the problem or contact with the professionals. Understanding how parental attributions change throughout therapy by considering the impact of therapeutic interventions may help to determine how to maintain parental engagement in child therapy (Morrisey-Kane & Prinz, 1999). Although currently there is no knowledge of parental process it appears that factors related to the parent may be related to whether a parent continues their child in therapy (Weisz & Weiss, 1993).

Parent Change

The changes that occurred within each parent, such as the lessening of stress and anxiety, were further indications of the process. Having a child in therapy resulted in changes within the parent despite not being directly involved in the child's therapy. In a similar vein Kazdin and Wassell's (2000) study of changes after treatment for a conduct disorder similarly found that the child, family and parent functioning changed. Parents of the treated child decreased in depressive symptoms and overall symptoms of stress. As well family relationships and support improved even though none of these areas of parent symptomology were specifically addressed in treatment (Kazdin & Wassell).

Crawford and Manassis (2001) included a parenting component to the treatment of childhood anxiety and found that parent symptoms decreased even though parent psychopathology or distress were not targeted. The authors suspect that gaining a better understanding of their child's symptoms allowed parents to gain an ability to manage their own distress. Parent involvement in treatment appeared to contribute to improved family interactions.

The process of parental involvement may be inherently linked to developing our understanding of how and why treatment works with children. This is consistent with Kazdin and Kendall (1998), who indicate that one of the important factors for developing effective treatments is to identify what the authors called "moderators" which are defined as factors (e.g., people) that interact with treatment such as the child, family, parent, and therapist. These "moderators" play a role both in the behavioural or emotional dysfunction of the child as well as in the treatment process (Kazdin, 2000; Kazdin & Kendall, 1998). Understanding the parental process may be an important component for understanding the child's therapeutic process. "Clinical impact of treatment will derive not only from outcome studies, but also from understanding the processes through which treatment works" (Kazdin & Kendall, p. 221). Increasing the attention that is paid to parents and their processes will facilitate understanding, development, and deliverance of child therapy and treatments.

Perception of involvement in the therapeutic process impacted each parent's experience. Parents in the study who viewed having a child in therapy as a positive experience, which contributed to changes in the child and themselves, were validated in their decision to seek therapy for their child. The experience was viewed as worth the effort and worth repeating again if necessary in the future. Parents who viewed their child's therapy as a negative experience were less satisfied and less likely to perceive change in their child. Initially these parents experienced the reduced anxiety and stress when they too were validated by the child's therapist as not to blame for the problems. However these feelings of anxiety returned along with new feelings of frustration and disappointment. Parental satisfaction of a child's therapy is found to be related to outcome with lower parental satisfaction being correlated with clinician-rated negative outcome (Rey et al., 1999; Rey et al., 2002) and children of satisfied parents eight times more likely to be rated as having a positive outcome with therapy (Rey et al., 2002).

Parents' Role in Child Therapy

Parents in the present study expressed a desire to play a role in their child's therapy beyond provider and receiver of information. There are various roles that a parent plays in facilitating the outcome of their child's therapy. Most parents of the present study did not play a direct or active role in their child's therapy nor did they regularly engage with the child's therapist. Parents' interaction with their child's therapist consisted primarily of providing information regarding the child at home and of receiving feedback regarding the child's progress. While some parents experienced the important experience of receiving validation as a parent there continued to be a desire by some to be more actively involved, particularly those who had a negative experience. Specifically, the desire was expressed to receive direction from the therapist on parenting and discipline at home between sessions. Parents also anticipated guidance on ways to change their own behaviour to impact their child's. It is important to have parent and child directly involved (Mendlowitz, Manassis, Bradley, Scapillato, Miezitis, & Shaw, 1999). While the focus needs to remain on the child's struggle, involving family members in the process is found to be essential to a satisfactory outcome (March, 1995).

Outcome Studies

Information and direct guidance from the therapist to aid in parents' understanding of the problem and ability to facilitate change with their child was desired by participants in the present study. Overall parental involvement in a child's therapy is an area that is not well developed in the literature as the role of parents in treatment has not been adequately addressed (Mendlowitz et al., 1999). One exception is the treatment of childhood anxiety disorders. Recently outcomes of children treated with no parental involvement have been compared to treatment in which parents are involved. Parental involvement in treatment of anxiety enhances treatment effectiveness, as parents provide feedback and monitor coping of child and play role of co-therapist outside of treatment. The findings of the present study support conclusions drawn by Bernstein et al.'s (1996) review of anxiety disorder research that parents desire feedback and education about the child's disorder and treatment plan.

Mendlowitz et al.'s (1999) study on the impact of cognitive behavioural treatment (CBT) with and without parental involvement found a significant change in use of coping strategies in children in the parent-involved group. The skills learned were used more frequently and children were rated as more improved than in the parent only and child only conditions. It is likely that parents involved in treatment are more likely to support children's efforts to cope and change.

Participants in the current study perceived involvement in their child's treatment as important, with those having little involvement and feedback from the therapist perceiving little change in their child. This finding is supported by research comparing parental involvement in the treatment of various anxiety disorders (Knox et al., 1996; Mendlowitz et al., 1999; Spence et al., 2000) and conduct disorders (Kazdin & Weisz, 1998; Multisystemic Therapy Services, 1998), which have concluded that parental involvement in treatment improves outcomes for the child and may even be a necessary component. The parental role in therapy contributes not only to parental satisfaction with the process, but to improved outcome and progress for the child when parents are involved in the child's therapy.

Some participants in the study had supportive relationships with the therapist. This, however, does not necessarily contribute to the child's therapy, as even most parents who had a negative experience felt supported in the early stages by the child's therapist. While support to the parent certainly contributes to the parents' process, as was noted when parents were validated by the therapist, parents needed more than this validation and support to continue to feel the therapeutic process was beneficial. The involvement of parents needs to be treatment focused and go beyond provision of support and understanding to parents (Sonuga-Barke, Daley, Thompson, Laver-Bradbury & Weeks, 2001).

Support to parents being necessary but not sufficient for positive outcome speaks to the necessity of a working relationship between the parent and the child's therapist. Support in and of itself may not be enough for a working relationship to develop. As discussed earlier a therapeutic alliance involves not only a warm relationship with the therapist, but also a focus on goals and specific tasks and procedures to reach goals (Bordin, 1994; Digiuseppe et al., 1996). It stands to reason that the necessity of parents to play an active role in the child's therapy requires a therapeutic alliance between parent and therapist and that parental involvement with the child's therapist likely contributes to the formation of the parent-therapist alliance.

Deciding Who is the Client

Having both parent and child involved in the therapy process is emphasized by the results of the present study. Clinically, therapists decide whether and how to include parents in the child's therapy. While parents and social context are acknowledged as important components that contribute to the child's ability to function, they are not incorporated into child psychotherapy literature (Havaas, 1999). Weisz (1997) emphasizes that the child's social environment, which includes parents, should be incorporated into the treatment process.

If the parents' involvement and interaction in the treatment process is an important component of the child's therapy, this raises the question of who is the client; parent(s), child, or both parent(s) and child. Therapists who treat children have to consider that it is the parent who brings the child to therapy and makes the decision whether to continue or end therapy. Whether therapy is received through a private service that parents pay for directly or a public service, parents have legal rights as the child's guardian. Hence, it first is acknowledged that parents are the primary consumers of child psychotherapy services. While parents are the consumers of child psychotherapy this does not make them the primary client of the child therapist. From the literature reviewed the involvement of parents in child psychotherapy was intended to improve the outcome of the child's problems, hence the child is the client. The current study supports that parental involvement is an important component to child psychotherapy. Even when parents are not formally involved by the child's therapist they are engaged in their own process that likely impacts the child's psychotherapy process and therefore should not be ignored. While the parents are to be considered an important component to the child's therapy process and improved outcome, the involvement of parents is geared towards the advantage of the therapist's client, the child (Sperling, 1997). If the involvement of parents in the child's therapy became detrimental to the child, (e.g., abuse or intentional interference with treatment) then this involvement would be discontinued. However, in most cases meeting the needs of parents for feedback and guidance regarding their child and engaging parents in a parent-therapist alliance is in the child's best interests, likely contributing to parents continuing with therapy and supporting the process.

Therapeutic Alliance

Parents who bring their child to therapy have a range of emotions and cognitions throughout the process but do not consider themselves patients or clients. However, the parent is often more anxious and concerned than the child and these parental attitudes can affect the child at home, and the outcome in treatment (Hoffman, 1984).

As alluded to by parents in the current study, if parents are to be involved in treatment there is a need for there to be a working relationship with the child's therapist to facilitate that involvement. Understanding how parental experience and internal dialogue are processed in relation to the child's therapist is important to engaging parents and facilitating outcome. The therapeutic relationship, as has been demonstrated by various adult studies, is recognized as an important ingredient in positive therapy outcomes, yet little has been done in child psychotherapy research to assess how these mechanisms work (Diamond et al., 2000; Hibbs, 1998; Nevas & Farber, 2001).

Parents' perceptions of their child's therapist in the present study tended to be relatively positive. A parent who did not describe the experience of having their child in therapy as positive still tended to describe the therapist in positive terms, while the other parent who had a negative experience described having no relationship with the therapist. The difference here, and the finding that even most with overall positive and negative experiences tended to be positive in terms in describing their child's therapist, may be the difference between a relationship and a therapeutic alliance that has qualities that contributes to a positive outcome. Even if the relationship is positive it may not necessarily be a relationship that contributes to the therapeutic outcome. Some parents in the present study described having a positive relationship and liking their child's therapist but at the same time did not feel their needs were met therapeutically. Understanding the feelings of parents about their child's therapy and therapist can facilitate an effective parent-therapist alliance, which enables the therapist to work effectively with the child and to reduce the possibility of parents ending therapy early as well as facilitating the change process in the child. Sonuga-Barke et al. (2001) emphasized that the relationship with the therapist needs to be more than supportive towards the parents, with therapy needing to be treatment focused. Such findings, as well as those of the present study highlight the importance of understanding what qualities in the parent-therapist relationship contribute to a parent-therapist alliance, which leads to improved outcome for the child in therapy. These findings also highlight that a therapeutic alliance is a phenomenon of which the relationship is only one part and possibly not sufficient to produce change.

Participants describing a negative experience tended to feel detached from the therapist, misunderstood and unimportant. These parents were also more likely to perceive little change in their child than parents describing positive experiences. When parents feel supported by the therapist, agree on the goals of therapy, and are involved in the child's therapy, then therapy is more likely to progress (DeChillo et al., 1994; Diamond et al., 2000). The range of feelings evoked by bringing a child to therapy, how these feelings influence the parents' experience, and how the parent deals with these feelings in relationship to the therapist are important to the progress of therapy (Nevas & Farber, 2001). Parent-therapist relationship factors are identified in the literature as contributing to early therapy dropout. Studies emphasize lack of communication as contributing to parental misunderstanding of therapeutic goals, lack of understanding and concern of the problem expressed by the therapist towards the parents, and parents not having the level of involvement in treatment they desire (Chung et al., 1995; Garcia & Weisz, 2002; Hawley & Weisz, 2003) as factors which contribute to parental decision to discontinue their child's therapy.

Similar to the current study's findings, Nevas and Farber (2001) explored the experiences of parents who were regularly involved in their child's therapy. Overall, these parents reported positive attitudes towards their child's therapist and the therapy. Parents felt they were provided sufficient consultation and understood the goals of therapy. The authors concluded that parental involvement enhances parental respect and support of the therapist and that parents are helpful partners in a child's therapy.

Models of Alliance

In the present study most parents described the bond with the child's therapist in positive terms but this did not necessarily mean the parents described the overall experience and outcome as positive. As previously discussed, definitions of therapeutic alliance stem primarily from within the adult literature. One of the most influential is Bordin's (1994) model that proposes a definition of alliance with an emphasis on collaboration in three domains: goals, tasks, and bond. What Bordin's definition emphasizes is that a therapeutic alliance goes beyond the bond to include agreement on tasks and goals. Parents in the present study who were more likely to describe a positive experience were also more likely to have been provided information and feedback from the therapist about the goals of the therapy and had a role with which they were satisfied. The experiences of these parents were more likely to have the other components of Bordin's definition, goals and tasks, as part of their experience compared to those who described the therapist, but not the overall experience, positively.

This speaks to the necessity of parents being involved in their child's therapy and for there to be a parent-therapist working relationship. Treatment of a child is at the very least triadic in nature. Parental importance cannot be denied or ignored. Collaborative relationships with the child's therapist may increase parents' understandings of the process and their own role in maintaining and changing symptoms in their child, which in turn increases the effectiveness of the parent and the therapy. While it is an extreme statement, Hoffman (1984) states that there can be no treatment of the child if no alliance between the parent and the child's therapist exists. The parent-therapist alliance is assumed in the clinical literature to help parents to accept the child's problem and increase compliance (Mufson & Moreau, 1998; Sperling, 1997); help parents understand the impact of their behaviour on their child (Lewis & Blotchy, 1997; Piovano, 1998) and reduce expectations for quick fixes (Lewis & Blotchy).

What is not addressed by Bordin's (1994) definition, or by other definitions of the therapeutic alliance in the literature, is the incorporation of parents in this definition. This is in part due to the adult focus of the therapeutic alliance research. Hence, the definitions tend to be dyadic in nature. As discussed earlier even the few definitions noted in child psychotherapy literature do not include parents and tend to focus on the dyadic relationship between the child and therapist (Digiuseppe et al., 1996). The dynamics and elements of child therapy differ from those of adult therapy. The present definitions in both the adult and child psychotherapy literature are inadequate to account for the processes that occur within the realms of child therapy. In adult psychotherapy the focus is largely on the individual adult client. In child therapy there are at least two participants whose concerns and perspectives may be legitimate and important: child and parent (Hawley & Weisz, 2003).

> It is likely that an adequate predictive model of child alliance formation will need to move beyond the developmental and psychopathological characteristics of the referred child to a consideration of familial and other social contextual variables that could influence treatment collaboration. (Shirk & Saiz, 1992, p. 725)

Collaboration

Participants in this study identified a need for collaboration with their child's therapist. They wanted communication and regular feedback, an explanation of the child's problem, and an opportunity to participate. DeChillo et al. (1994) identified four characteristics of collaboration between parents and therapists: a supportive relationship, practical arrangements, open information exchange, and a flexible approach. DeChillo et al. felt therapists need to recognize the perspective of parents and seek their input and involvement in the process and decision making. Collaboration is more likely if parents feel they are informed, being heard (Grunebaum & Friedman, 1988; Winefield, 2000), and treated with respect (Winefield). Unfortunately, as Gaines (2003) stated, many therapists avoid meeting with parents for unknown reasons that may have to do with the therapist's comfort level regarding parental involvement and interaction. Currently he views work with parents as a hybrid approach of which an adequate model has yet to develop.

Multi- System Perspective of Child Therapy

Unlike adult therapy, child therapy is triadic in nature (Nevas & Farber, 2001). Based on the current findings, parents are impacted by having their child in therapy. It is a process that goes beyond bi-directional; it is multi-directional, reciprocal and interdependent in nature. The parents' process makes visible that having a child in therapy influences their emotions and internal dialogues. The therapist has influences over the process of both the parent(s) and child, which in turn influence the child's therapy. This is a circular, multi-directional process characteristic of a system.

The child in therapy needs to be viewed from a developmental ecological perspective, of which the dyadic interactions in the family system are one part. The interactions and influences of the parent, child and child's therapist certainly meet Bronfenbrenner's (1977, 1986, 1992) definition of a mesosystem. A lack of research into the parental contributions to successful therapy reflects a failure to understand the influences of the mesosystem beyond the direct effects on the child (Bronfenbrenner, 1986).

There is a need to alter the focus of current research to other influences and contexts where a child functions (Hibbs, 1998; Kazdin & Weisz, 1998) beyond the current focus on symptom reduction. Understanding of the multi-directional influences of a child's context is necessary to understand what works and why. Most of what is known about child therapy presently is from the dyadic perspective of therapist and child and/or a measure of child therapy outcome in controlled studies (Weisz, 2000; Weisz et al., 1992). The research focus on symptom reduction within the child as a measure of outcome fails to address effects of child therapy beyond the direct effects on the child.

Viewing a child as embedded within a multi-systems context does not mean that practice needs to be contained within the family therapy models. While those in the field of family therapy view the child from a systems perspective, individual child therapy can also be practiced from such a conceptualization. Kazdin and Weisz (1998) make a call for "family context" therapy that needs to be independent of the conceptual view that underlies treatment. Regardless of the theoretical orientation of the therapist the importance of the parent cannot be denied (Nevas & Farber, 2001) and there is a need to conceptualize the child's functioning as embedded within the multiple contexts and influences. More needs to be known about these other facets of a child's life as they contribute to the therapeutic process. Child psychotherapy research rarely identifies the "effective ingredients" of treatments, and more needs to be known about these ingredients and how they interact to produce change (Kazdin & Weisz).

Understanding the process, perspective, and expectations of parents who have a child in therapy may contribute to further the understanding of how and why treatment works. The experiences of the parents in the present study highlight the reciprocal factors that impact children in therapy. There is a need to recognize the multi-system and multi-directional nature of a child's life that goes beyond the dyadic therapy session. While child researchers have gathered evidence to support preferred treatment choices for some specific childhood disorders (Kazdin, 1994; Kazdin & Weisz, 1998; Weisz et al., 1998) there is little known about how child therapy works (Hibbs, 1998; Kazdin, 2000) and a treatment of choice can fail.

A synthesized view of the ingredients that contribute to improved treatment results and symptom reduction is a current gap in child psychotherapy research. Working to expand not only the understanding of the processes of behavioural or psychological change, but also the aspects of the individual's environment that interact with the therapy process to produce and maintain change (Hibbs, 1998), would contribute to closing this gap.

Conceptualizing the child in therapy as part of a larger system and understanding parent experience and process will contribute to understanding why and how adding parental involvement may improve treatment. A multi-system perspective regardless of the therapist's or researcher's orientation would provide a theoretical basis and understanding for child therapy to be built upon.

Implications for Practice

As ethical psychologists, we are bound to fully inform clients about the nature of the services they are to receive (CPA, 2000). Informed consent comes from the parents who bring their child to therapy; hence, parents likely would benefit from awareness of treatment choices and options. The practice of engaging parents in a process of informed consent should include a discussion of the nature of the child's difficulties to provide a rationalization for the goals of therapy. Having an understanding of the therapeutic goals may help parents feel involved in the therapeutic process and allow them to make contributions to the process.

Parents ultimately decide to maintain or discontinue treatment and therefore need to be involved in an information and decision-making process. Receiving basic information regarding the provision of services is a necessary component to link parents into the therapeutic process and an alliance with the therapist.

Parents require information from the outset about expectations of them throughout the process. If it is expected that parents or child are to complete homework between sessions, if parents are to monitor or coach progress at home, or even if it is felt that it is best for parents to be more in the background, they need to be aware of these expectations. Parents are more likely to feel that they contribute to the process if the expectations are set at the outset. Therapists need to acknowledge that parents enter the therapeutic process with expectations. Whether these expectations are accurate or not, they are nonetheless present. Providing parents with information may prevent these expectations from interfering with treatment outcome. Nevas and Farber (2001) recommend that parents be informed about what their role will be, what kind of outcome can be expected, and the limitations of therapy. Therapists should offer opportunities for parents to discuss not only the child's symptoms but also their own concerns and needs regarding parenting the child, with the therapist offering support and guidance (Nevas & Farber).

Parents in the current study wanted: 1) information regarding their child's problem, 2) input into the treatment goals, 3) open communication, 4) opportunities for discussion of progress and concerns, 5) guidance on how to help their child at home, and 6) to know how they could contribute to their child's treatment. Meeting periodically with parents and offering opportunities to discuss progress, disappointments, and even their own process acknowledges that parents, too, are experiencing a process characterized by emotions, cognition, and behaviours that may need addressing. Opportunity for discussion with the therapist may provide parents with the important perception that they play an important role in their child's therapy.

Collaboration between the parents and the therapist can be enhanced by acknowledging that the working relationship or therapeutic alliance between the parent and the therapist may be as important as the alliance the therapist has with the child. Most therapists would agree on the importance of developing a therapeutic alliance with the child; however, there are differing opinions regarding level of parental involvement. The role parents play can vary, with involvement ranging from the parent as co-therapist to the parent who primarily is relegated to the waiting room. Regardless of the level of the parental involvement, a parent-therapist alliance is an essential ingredient that deserves attention. Therapists need to be cognizant of this relationship and the potential breaks that may inhibit the child's therapeutic progress and even result in premature termination of treatment. Viewing the child from a multi-system perspective and the therapeutic relationship as triadic in nature at the very least will facilitate collaboration between the child's therapist and parent.

Finally, as recommended by Friesen (1992), all professional educational programs, regardless of discipline (e.g., psychology, social work) should attend to parent-professional relationships. Currently the literature is not clear on how these relationships are important and thus is poor for informing practice. However, educational programs have the benefit of instructors with clinical experience which could add to the understanding of these relationships for professionals in training.

Implications for Future Research

The current focus of child psychotherapy literature is narrow in its focus. Outcome studies focused on symptom reduction help us to understand what therapies have potential for contributing to the best outcome for the child. While outcome studies are necessary, they fail to help us understand child therapy processes that contribute to change or what factors may interfere with expected progress. There are important features of a child's life that are not captured by current empirical studies which are focused on outcome through measurement of symptom reduction. Understanding outcomes beyond this are important because of the significance to the child and the context in which the child functions (Kazdin, 2002). Current research does not adequately capture the ingredients that contribute to symptom reduction, and there is a need to expand child treatment research to other areas of the child's functioning. Current understanding of child psychotherapy is restricted to the conclusions and assessment of treatment outcomes that are currently dominant. There is also a failure to incorporate developmental literature within these studies. Other broader effects may be as important as measured changes in the child. These other broader domains also play a role in the outcome and changes that are measured.

Conceptualizing the child as functioning within a system and considering these interactions as contributors not only to outcome but also to the psychotherapy process, is the next step to be taken in child psychotherapy research. Expanding the understanding of psychotherapy process beyond the microsystem and the direct effects on the child will enhance our understanding of therapeutic process and the factors that contribute to symptom reduction. At the very least, perceiving child psychotherapy as a relationship that involves the parents, child and therapist with interacting effects is necessary. To date parent process is an unrecognized component of child therapy which requires further investigation not only as a phenomenon in and of itself, but as it contributes to the child therapy process, the relationship with the child's therapist and to outcome.

The present study highlights the need to recognize the parent-therapist alliance. It is inappropriate for a trickle down effect to occur with the adult understanding of therapeutic alliance being applied to the child psychotherapy dynamic. "Child therapy fundamentally differs from adult therapy in ways that may make key findings from adult treatment inapplicable" (Nock et al., 2001, p. 156). The parent-therapist alliance and contribution to treatment completion and outcome is an area to be further studied.

Broadening the view of child psychotherapy research will contribute to an understanding of how and for whom treatment works. Until there is a better understanding of these questions the development of an understanding of child psychotherapy process and of child treatments will be hampered. Answering these questions will allow the research-practitioner gap to begin to close, providing the practitioner guidance on what treatment choice may work for whom. In real world practice, therapists need to be able to match more than a treatment to diagnostic category. Research needs to go beyond what works.

Considerations For This Study

This study may be influenced by the counsellors used. All but one therapist was a doctoral student. Parents involved with more experienced therapists may have different experiences, as therapist skill may increase with years of practice. As well, only one father participated in the study. It may be that fathers and mothers have different perceptions of the experience as well as different expectations at the outset. However, it is not the intention to generalize these results to those who did not participate.

The therapists did not adhere to similar treatment models of practice. Therapists described themselves as eclectic in nature. It may be that parental response and processes differ with different theoretical orientations of practice. The results of this study are not meant to generalize to any particular therapeutic model or diagnostic category. Instead they should be viewed as a general view of the participants' overall experience that may or may not be applicable across theoretical orientations.

The poor response to the written synthesis provided to participants leaves the researcher to rely on her own interpretation, although the information provided by the participants was triangulated with the research literature. As well, the few responses received were positive with no corrections or additional information provided to the synthesis. No response may suggest that participants were satisfied with the interpretation of their experience and felt no need to provide an additional response.

Summary

This study was an attempt to understand how parents experience the relationship with their child's therapist. The expectations parents have for this relationship and for their role in therapy were explored. The interactions with the therapist had a powerful impact on the experience of parents. These findings indicate that parents experience a process throughout their child's therapy that is characterized by internal dialogues. Through this self dialogue parents process their expectations and emotions in relation to the actual therapy experience. Parents experience a range of emotions such as self-blame, guilt, stigma, and fear. These parents desired to have an active role in their child's therapy and were distressed when this expectation was not met. The experience of parents gave emphasis to the multisystemic and triadic nature of the parent-therapist relationship.

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APPENDIX A

Advertisement

Has your child been in therapy?
Your experience as a parent is important to us.
If interested in participating in this research project please contact:

Julie 486-7987 or Robin 492-1163

APPENDIX B

Study Description

Research Project:	Parent perceptions of their relationship with their child's counsellor Department of Educational Psychology 6-102 Education North, University of Alberta Principal Researchers: Julie Wall-MacDonald and Dr. Robin Everall Phone: 492-3746 or 492-1163

The purpose of this study is to gather information regarding experiences of a parent when their child has undergone counselling. Little is known about therapy with children from the parent perspective. My intention is to gain an understanding of what parent's experience when their child is engaged in the counselling process. It is hoped that this information will be helpful in understanding the impact the therapeutic process may have on family life and on the child. Such an understanding is necessary to providing intervention to families.

This is a voluntary project and you may participate or withdraw at any time without penalty. Your name or identity will not be recorded except for the purposes of contacting you for an interview, and your name will not be given out to anyone and will be known only by the researchers. Participation will involve two interviews. The first interview will be approximately one half hour to two hours long at a convenient time, asking you about your experiences while your child was receiving counselling. The second interview will be approximately one hour. The interviews will be held in the Education Clinic at the University of Alberta. When transcribing the interviews the researcher will use pseudonyms, which will also be used in writing the final report. The researcher will be the only one with access to the tape recordings and interview transcripts, and these will be stored in a secure place. Audiotapes will either be returned to the participant or erased at their request once the study has been completed. There may be some risk that talking about your experiences may cause you some distress and that, if required, additional counselling referrals will be made available to you by the researcher.

APPENDIX C

Participant Informed Consent

Research Project: Parent perceptions of their relationship with their child's counsellor
Department of Educational Psychology,
6-102 Education North, University of Alberta
Principal Researchers: Julie Wall-MacDonald and Dr. Robin Everall
Phone: 492-3746 or 492-1163

I, ____________________________, am aware that the purpose of this study is to gather information regarding parents' experiences while their child has undergone counselling. The researcher's intention is to gain an understanding of what parent's experience when their child is in counselling. It is hoped that this information will be helpful in understanding the impact the therapeutic process may have on family life and on the child.

Through an interview I will be asked to describe my experiences while my child was in counselling. I understand that this is a voluntary project, and I may participate or withdraw at any time without penalty. If I choose to withdraw, any information or data that I provide will be destroyed. I understand that my name will only be recorded for the purposes of contacting me for an interview, and that my name will not be given out to anyone and only known by the researcher. I understand that participation will involve an interview of approximately 50-70 minutes long at a convenient time. Following the researchers analysis I will be asked to return for a shorter interview. I understand that there may be some risk that talking about my experiences may cause me some distress and if required counselling referrals will be made available to me by the researcher.

I am aware that all information I provide is strictly confidential. When transcribing the interviews the researcher will use pseudonyms, which will also be used in writing the final report. Any details in the interview recordings that might identify me or any persons that I mention will also be changed during the transcribing. Furthermore, the researcher will be the only one with access to the tape recordings and interview transcripts, and these will be stored in a secure place. Audiotapes will either be returned to the participant or erased at their request once the study has been completed. Signed informed consent forms will also be stored in a secure place separately from other data.

I am also aware that the information obtained from the interview may be used for future research and the transcript of the interview may be included in the appendices of the researcher's paper.

I, ___________________, give my informed consent to participate in the research project
(Name of Participant)

....
(Date)

....
(Signature of Participant)

....
(Signature of Witness)

APPENDIX D

Interview Guide

1. Could you please describe your experience of the relationship between yourself and your child's counsellor?

2. a) Did you have expectations about having a relationship with your child's therapist?
   b) What expectations, if any, did you have for this relationship prior to bringing your child to counselling? How have these expectations been met/unmet?
   c) Were your expectations similar or different from those of your child's other parent? If so in what ways?

3. a) Please describe the role you perceived yourself playing throughout your child's therapy?
   b) Describe any ways the relationship with your child's counsellor may have influenced this role? (discussion of parental roles may include: goal development, performance of tasks, providing information to counsellor, primarily left in waiting room)

4. What impact, if any, did you hope for in your family by bringing your child to counselling?

As well as discussion of emotions, thoughts, events, situations, activates, and communications with others, and impacts of behaviour during the counselling period.